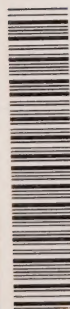


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Health Care Organization of the Future?

COMMUNITY HEALTH CENTRES:
HEALTH CARE ORGANIZATION OF THE FUTURE?

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REPORT TO THE COMMITTEE
ON COMMUNITY HEALTH CENTRE PROJECT

BY

ANNE CRICHTON, Ph.D.

July 1972





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"This report could not have been written without the help of the many people who are listed on Appendix D of Volume I, the Report of the Committee to the Conference of Health Ministers. In this listing can be found the titles of all the papers commissioned for the project, briefs submitted to the project, reviewers' names and personal communications.

In this report a list of references follows each chapter. Authors who submitted commissioned papers are underlined, as are reviewers and others who submitted comments. Published authors are not underlined.

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The report was prepared under considerable pressure of time between April and July 1972 and has not since been rewritten."

Anne Crichton
July 1972

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TEN MAIN ISSUES: A PERSONAL VIEW

The main issues which will have to be considered if a policy of establishing Community Health Centres is to be implemented are:

1. There is need for change in the cost-sharing arrangements between federal and provincial governments in order to free the provinces to develop new health care delivery organizations. This should include giving consideration to the amalgamation of health and welfare funds into one shared cost program so that medical care can really become health care.
2. There is need to develop a general health care system in which community health centres can fit concurrently with the development of significant numbers of such centres.
3. There is need to consider the two objectives of health centres as separate issues:
 - (a) less wasteful use of resources.
 - (b) redistribution of power between professionals and consumers.
4. There is need to consider the strategy of change - how far and how fast to go.
 - (a) Is it wise to develop health centres to meet objective 3 (a) as a first step?
 - (b) Is it better to start community health centres in areas where there is no service now?
 - (c) Should community health centres be encouraged to develop in free competition with other services?
 - (d) Should public policy encourage a high degree of consumer involvement or establish rigid national or provincial norms of resource provision?
5. Change will come about through negotiation but the governments have the power of the purse. They may decide to offer a variety of incentives to encourage the development of the

models they wish to promote. It should be recognized that negotiation proceeds formally and informally about functional and substantive matters.

6. Allocation of resources will not be easy, and a great deal of time to develop good models of resource allocation will be required.
7. Continuous monitoring and independent evaluation of health centres will be very important. Predictive or anticipatory models should be set up. The models should establish norms and deviations from these norms should give warnings about possible failures to attain objectives.
8. Manpower problems will loom large. Good personnel policies should be established at federal, provincial and local levels in order to give community health centre employees the advantages of belonging to a large scale organization. Manpower policies should include policies for the involvement of local people as employees or voluntary workers in their community health centre.
9. Consumer involvement should proceed gradually. Consumers will have to learn how to work with professionals. They will need to find out about the issues in health care, the techniques of committee work and the substantive areas in which they can make a contribution.
10. Community health centres will have to develop new organization structures and processes in order to meet the objectives in 3 (a) and (b).

SUMMARY OF THE PAPERS SUBMITTED ON SOCIOLOGICAL, EPIDEMIOLOGICAL AND OTHER TOPICS

INTRODUCTION

Dr. Hastings and the Committee of the Community Health Centre Project were given one year from July 1971 to gather evidence about community health centres and to reach recommendations to be presented to the Conference of Health Ministers. Given these tight time limits there was no prospect that a new experimental design could be developed and executed, and in any case experimental research seemed inappropriate. What the Ministers appeared to want was a synthesizing of already available evidence, and the development of informed hypotheses by experts from studies of the on-going situation in Canada and from comparative studies of other countries' experience; an evaluation and assessment of the dynamics of Canadian health care.

The questions which the Community Health Centre Project was asked to address are political, though not party political. Thus, the evaluation has had to be concerned not only with 'hard' data about the economics of health care, or epidemiological outcomes, but was also required to consider attitudes and values of Canadians and their readiness and willingness to change. For the introduction of community health centres on more than a demonstration basis would inevitably result in a redistribution of resources and of power.

This paper brings together the sociological, epidemiological and general evidence which was collected (everything but the economic and accountancy evidence which is summarized in Dr. Peter Ruderman's paper). Few 'hard' data were available, and the conclusions are drawn mainly from a wide range of experts' opinions. The differences in the approaches of the epidemiologists and sociologists have been difficult to reconcile, particularly in regard to evaluation, for the epidemiologists are concerned mainly with health outcomes, admittedly very hard to pin down and process of delivering medical care and the sociologists mainly with communications and the processes of change in society.

This paper begins by examining ideas about community health centres - how the concept has been defined and tried out elsewhere. It goes on to consider the existing institutions for ambulatory health care in Canada upon which any new system would have to build.

The problems of meeting health care needs with the present methods of deploying resources are examined. There follows a discussion of the ideologies underlying the social policies of different Canadian governments and how these appear to affect the development of social services, including health. Subsequently, there is an exploration of the implications of the community health centre concept for Canada - what are the constraints imposed by medical technology, administrative divisions, the willingness and ability of organized groups such as the health professions, hospitals or health departments to change? What are the organizational dilemmas that must be faced and organizational choices made by institutions which may become involved in altering the present wasteful system? Can a new pluralistic system be viably proposed? Research and evaluation techniques are examined.

Finally, some difficult choices are proposed.

The sources upon which this report is based are:

1. Original papers commissioned for the study by numerous Canadian and several international experts;
2. Original papers prepared as a basis for discussion of
 - (i) attitudes of health professional groups to community health centres;
 - (ii) attitudes of other institutional groups in the health field likely to be affected by the development of community health centres (e.g. hospitals, public health and mental health services, welfare services);
 - (iii) consumer involvement;
 - (iv) architectural design.
3. Reports of seminars
 - (i) on the papers listed in 2
 - (ii) on legal issues
 - (iii) on financial issues.
4. Reviewers' comments on all of the above;

5. Unpublished papers (sometimes prepared for publication elsewhere by their authors) and letters from experts in Canada and other countries;
6. Published books and articles, many from international sources, which were sent in to the Project office by correspondents or discovered by research assistants, Robert Thompson and Ann Coates;
7. Comments in submissions to the Project, solicited and unsolicited;
8. Personal observations in Canada, the United Kingdom, the United States, Holland and Belgium;
9. Comments from Committee members, from Dr. Peter New, Dr. David Fish and Dr. D. O. Anderson on drafts.

SUMMARY

Are community health centres likely to provide a solution to the problems of providing health care in Canada by increasing accessibility to health services, by improving acceptability of care, by reducing costs of the medical care component (or at least reducing cost escalation)? Will community health centres provide opportunities for skilled health manpower to be used more effectively? Ought they to offer consumers more chances to become involved in the planning management of health services institutions? What in fact are community health centres?

WHAT IS A COMMUNITY HEALTH CENTRE?

HEALTH CENTRES: SOME INTERNATIONAL CONCEPTS

Roemer⁽¹⁾ examined the files of the World Health Organization to explore the meaning of "health centre" and suggests that there are three broad types:

- (i) primary care centres - either preventive or curative or both (i.e. integrated)
- (ii) specialized service centres - directed to the exclusive care of certain diseases (e.g. T.B.) or certain population groups (e.g. school children or industrial workers)
- (iii) comprehensive polyclinics - combining primary care with advanced or specialized medical services.

He writes that the first integrated health centres were developed in the Soviet Union: "With its socialist philosophy, this country disregarded the entrepreneurial interests of private physicians, and soon after its 1917 revolution began to construct a network of health centres offering both preventive and curative services. Primary health centres were part of a regionalized framework of facilities, leading to polyclinics and hospitals at higher echelons".

The Soviets, like Canadian governments have to provide services to a widely dispersed population and the concept of using feldshers (or physicians' assistants) - the way in which medical services are provided in rural Russia - has been of interest to Canadians for some years. Last year a Canadian delegation visited Siberia to see northern health centres and the feldshers at work. (2)

The concept of an integrated primary care service was put forward in an official document in the Dawson Report in England and Wales in 1920.⁽³⁾ The United States followed this with discussions in the early 1920s⁽⁴⁾. Health centres, in the western sphere of influence, were started in Ceylon in 1926 with

Rockefeller funds. According to Roemer they emphasized preventive services "as a sort of countervailing force to the previous emphasis on hospitals and curative services in the developing countries". They were prepared to deal with treatment only in extreme emergency.

The separation of diagnostic and treatment services is presently particularly obvious in Belgium where health centres have been set up for the purpose of screening groups of school children, or workers, or old people, but without follow-through when medical problems are discovered.⁽⁵⁾ A similar separation between prevention and diagnosis and treatment, which is the responsibility of private practitioners, exists in the presently constituted public health departments of Canada. This separation of prevention from treatment services is purposeful in the Ceylon experiment but in Belgium separation results from financial organization rather than professional conviction. In Canada, this administrative division also causes some concern.

France has had financial difficulties in maintaining established health centres. Lack of flexibility in the social security system has affected the comprehensiveness and thoroughness of the services offered. Roemer describes how:

..."there has been a growing movement for private doctors to work in teams with ancillary personnel under one roof. These units are described as "centres de santé" although they are not usually operated by governmental bodies and they have a wide diversity of attributes"⁽⁶⁾. Some offer organized preventive services for various categories of persons or diseases. Their financial support comes from reimbursement fees. The income is pooled and the doctors are paid by salary. The 2000 health centres are now in financial difficulty. Private doctors cope with this by charging supplementation. Health centres have agreed not to do so and are consequently having great problems.

The importance of closely linking surveillance, maintenance and restoration was first realized in the group practice pre-payment plans of the United States. Group Health of Puget Sound⁽⁷⁾, the Health Insurance Plan of New York⁽⁸⁾ and Kaiser Permanente⁽⁹⁾ offer continuing and comprehensive care to enrolled members. These plans have consumer boards.

One question which has been asked about the United States prepayment plans is whether they have a representative enrolled population, since H.I.P. and Kaiser Permanente were started as employee group programs. What difference in their financial viability would it make if there were a high proportion of old people or welfare recipients among the enrolled members? Group Health of Puget Sound and Kaiser Permanente, Portland, have now admitted groups of welfare recipients to their schemes in order to explore this question.

Another question is whether these schemes and other prepayment insurance plans have boards really representative of consumers⁽¹⁰⁾.

In the United States, Health Maintenance Organizations (HMOs) have been proposed as a development of these prepayment schemes⁽¹¹⁾. They may be sponsored by consumers, providers, educational bodies or governments so long as they meet four conditions: They must have:

- (i) an organized delivery system
- (ii) an enrolled population
- (iii) a financial plan which includes hospital care
(As Mott ⁽¹²⁾ points out: "from this comes the physicians' incentive to control hospital use")
- (iv) a managing organization.

Health Maintenance Organizations may provide a compromise in solving problems of health service financing, somewhere between unregulated entrepreneurial and socialist answers.

In England and Wales, the National Health Service Act, 1946, designated health centres as the first level of a medical care system, but there were many reasons why they failed to get started when the National Health Service came into operation. It is only in the last few years that there has been a commitment to develop more than a handful of health centres, but now there are plans for approximately 500 to be built by 1975. Although a shortage of financial resources existed after 1951, it was not the main reason for the delay in developing centres. Considerable opposition to the concept came from the medical profession. General practitioners were reluctant to enrol in the National

Health Service, and were particularly hostile to health centres which (they seemed to think) would take away some of their autonomy. It took a generation for attitudes to change. These were the factors which influenced change in 1964:

- (i) grouping of general practitioners
- (ii) payments for better management of practices (incentives built into capitation payment systems by 1965 agreement)
- (iii) buying out of "goodwill" (1946) and new arrangements for low interest mortgages, rent rebates, etc. for development of practice premises (1960s)
- (iv) secondment of public health staff to health centres which became recognized as an important subsidy (1960s)
- (v) need to bring general practitioners into a system of continuing education, first recognized in 1914 and financed in 1968
- (vi) need to link general practitioners and specialists more closely.⁽¹³⁾

MEDICAL CARE AND HEALTH CARE

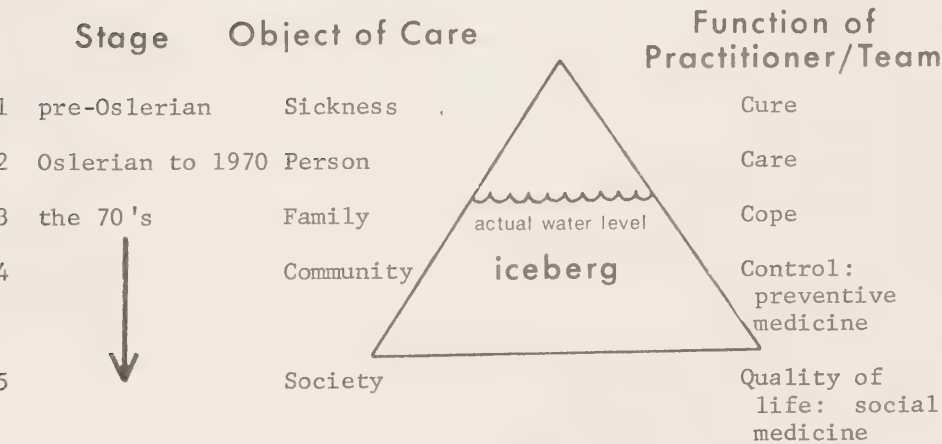
Questions were raised in Britain in the 1930s about the scope of health care as compared with the delivery of medical services. The Peckham Health Centre, set up in South London in 1935 and closed in 1939 due to the war, emphasized surveillance through annual checkups, family membership of the centre, and recreational activities, in an effort to combat urban alienation⁽¹⁴⁾. But the centre, reopened from 1946 - 50, failed to survive. Roemer comments:

"There is a lesson, perhaps, in this ultimate failure of a health centre concept which essentially excluded curative services and could not be incorporated into the administrative structure of the National Health Service operating all around it".

There may have been other reasons too. The physicians' seminar sponsored by the Project brought up different approaches to medical care. In a paper written for the Project, Delva developed a model which was discussed by all professional groups in seminars(15) (16). The medical specialist practices at the top of this pyramid, the family physician lower down. In a brief to the Project, the College of Family Physicians described their approach(17). "We believe that the most satisfying, efficient and cost effective system for delivering this (community) care is centred on the activities of the specially trained Family Physician working with the specially trained Family Practice Nurse in purpose designed premises, and relating closely to Specialist Consultants, other Health Professionals and Community Health Education and welfare organizations".

Some family practitioners with a special interest in the quality of life of their community might wish to practice in community health centres which would be lower down the pyramid than the family practitioners concerned with individual's problems.

CHART I - THE MEDICAL MODEL OF FAMILY CARE



Funkenstein has described the changing approaches to medical education on this side of the Atlantic⁽¹⁸⁾. Discussing American medical school development he sees four stages:

1. Pre-Flexner: low standards, disorganized curricula;
2. Post-Flexner: 1910-35: good standards, emphasis on a broad general training;
3. Specialist excellence: 1935-69: emphasis on research and its implications for practice, greater specialization;
4. Community centred interest: 1969 -

In Canada, four recently established schools, Memorial, Sherbrooke, McMaster and Calgary have found it easier to develop curricula that emphasize community health care than do the schools established earlier. It is not easy to develop new curricula in already existing schools.

The family physicians' status position is still in process of being developed. With the swing of the pendulum back from the strong emphasis on bio-technical specialization, some reconsideration has been given to their status within the medical professional group and to their levels of remuneration, but the specialists are still at the top of the medical hierarchy. The family practitioner in the community health centre would be found at the bottom of the pyramid working with the health care teams inside the centre and the community around the centre. (See Chart 1)

There is a movement away from the medical model towards other sorts of health service organization. Health sciences centres are being developed in universities⁽¹⁹⁾. This co-ordination of professional training activity is based on the concept of teamwork. Medicine, nursing, pharmacy, rehabilitation medicine, and social work schools have been attempting to find ways of bringing students together for instruction so that they may become accustomed to working in teams and will wish to continue to do so when they start to practice. Teamwork has been an important concept for hospitals and is now being presented as an even more important concept for community care. But the concept is seldom analyzed and it conveys different ideas to different professionals.

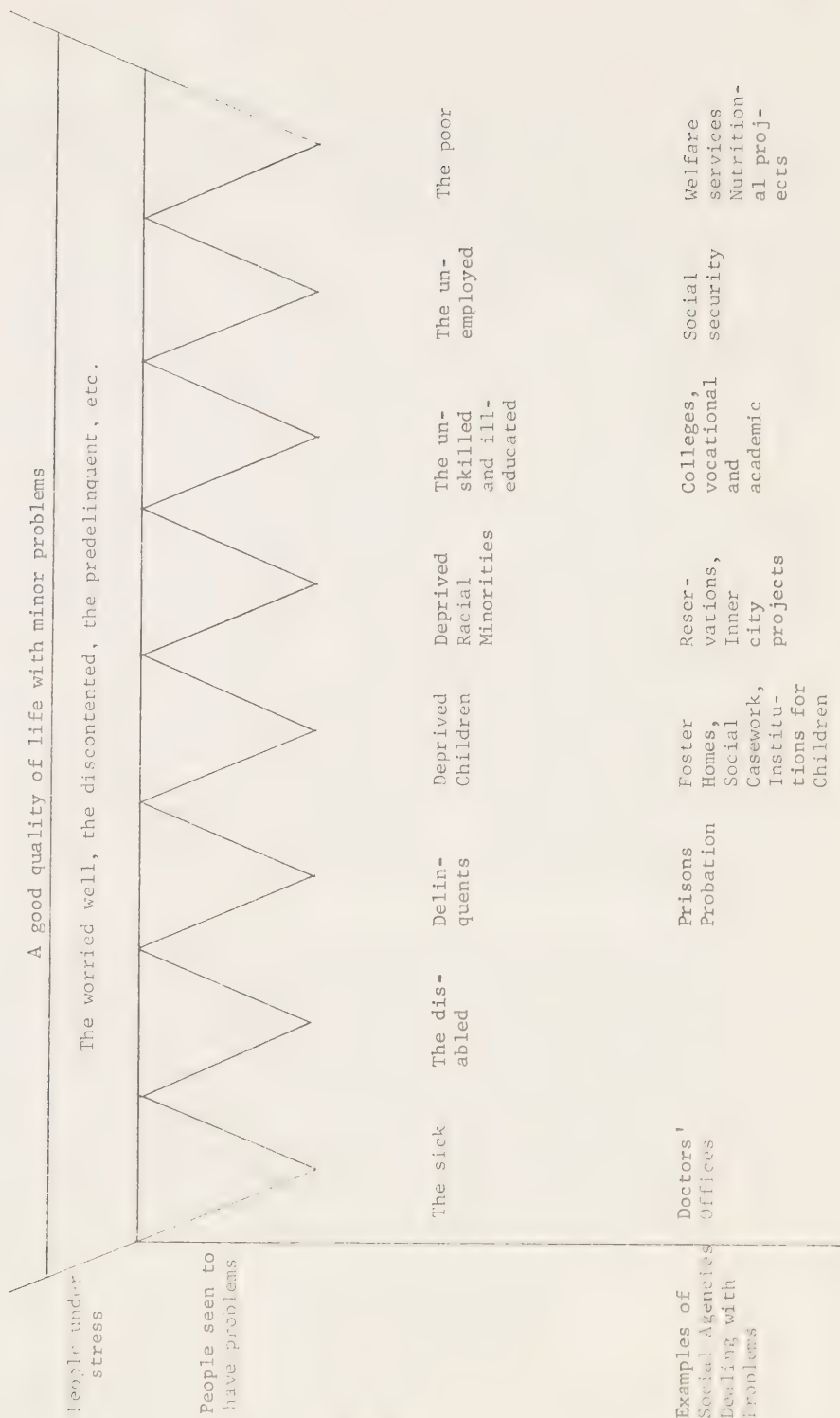
With the movement towards teamwork the medical model is challenged. The status of the physician is no longer always perceived to be that of the leader by the other health professionals who may wish to make assumptions about equality. As New⁽²⁰⁾ says: "Teamwork is often presented as the sine que non of getting things done...a call is issued for a team of experts in different areas of competence so that all certain knowledge can be pooled in a unified attack on any problem..." In an analysis of six assumptions pertaining to teamwork: equality, knowledge, professions, marginality, task and domain, New applies the sociological concept of cognitive dissonance and suggests that success or failure in teamwork can best be explained by the degree of dissonance that is inherent in the assumptions.

The concept of teamwork may be difficult to work out in practice but it is the only concept which is basic to all health centre models in Roemer's review of world developments. It should be noted that health care teams may not need to have physicians. The personnel in the team would be appropriate for the problems they were trying to deal with, thus a health team might be a group of nutritionists or nurse-midwives as in the northern outposts.

In a paper prepared by Coates^(16c) for the seminar on mental health service and their relationship to community health centres, the medical model was challenged. Why should the physician be at the top? He was, after all, only one of a whole series of problem solvers. What was important was to make sure that members of the public had the opportunity to sort out whether they had a problem and, if so, to discover where it could best be solved.

A group of sociologists, Bell, Fish and New, met with the project research co-ordinator to discuss the concept of non-medical models. They pointed out that instead of putting the physician at the top, one might put the needs of the community first, and then look at community members' problems. In general, the community should be able to provide a good quality of life to its members but people might think they had problems and then they would seek support from the social services. How problems were labelled was often a matter of chance.⁽²¹⁾ Families with problems might consult any one of a range of agencies or might never find their way into the system. (Chart 2)

CHART 2 - THE LABELLING OF PROBLEMS



Many people, then, who need help are unable to get it, and others who do not particularly need it but who are articulate and have time to seek out professionals to talk about their problems do receive help⁽²²⁾.

The mental health seminar group thought that many problems might be labelled as medical problems when in fact they could be solved by a non-medical person whether professional or volunteer. The medical model was wasteful because many matters now being dealt with by physicians could well be dealt with in other ways.

Coates presented a chart (Chart 3) which shows how problems might be identified and manpower used more effectively.

One problem is that of identification, another is that of delegation or allocation to another team member. The CELDIC report⁽²³⁾ had challenged the way in which psychiatrists organized their work. They were said to be unwilling to delegate and to admit that others could treat patients as well or better than they could. Warner⁽²⁴⁾ has recently found that general practitioners in British Columbia are equally unwilling to delegate non-medical problems.

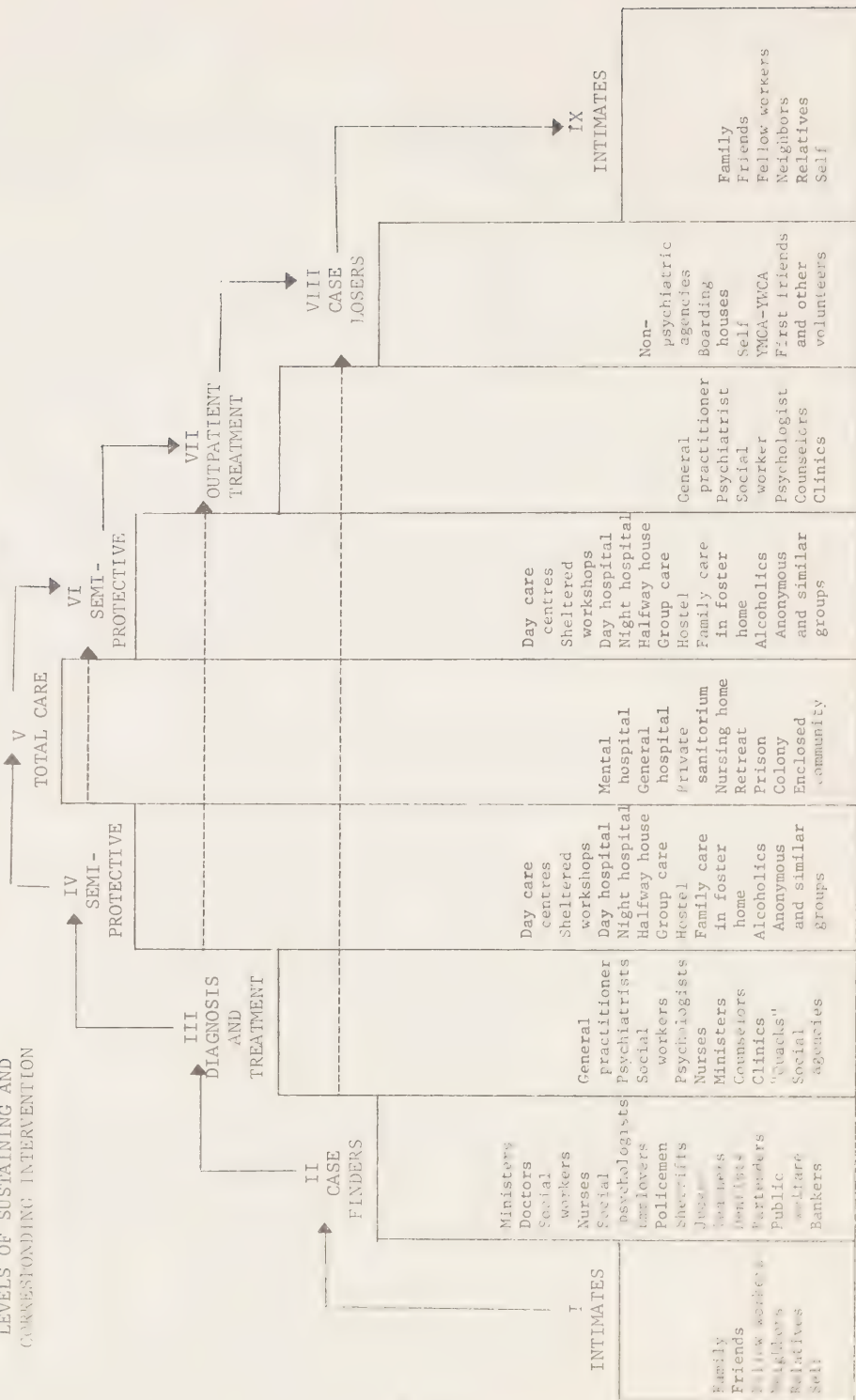
It will be noted that Coates' chart develops a continuum of care in which families are supported by other members of the community first and only in the last resort do they seek or get referred to professionals for help.

The development of a model of this kind presupposes community responsibility, that "no man is an island unto himself" and that individual health is rooted in community health. In the post-industrial society of today, communities, national and local, tend to lose sight of their less articulate and less powerful members whether in rural areas or poorer parts of cities. Community development or animation sociale is proposed as a method of developing healthier communities. It is health education in a broadest sense.

In a seminar on Consumer Involvement ⁽²⁵⁾ it was pointed out that deprived communities may react in different ways to their situation. Rural families tend to show general social apathy, but a great deal of aggression is turned in on the families, whereas in urban ghettos the aggression may be expended on others living and working in the neighbourhood.

CHART 3 - IDENTIFICATION OF PROBLEMS

LEVELS OF SUSTAINING AND
CORRESPONDING INTERVENTION



Where communities are living at a depressed level, problems arise in knowing how and where to begin to raise the level. Frequently, attempts to break the cycle of poverty and deprivation have been ineffective. Experiences in trying to develop communities in depressed areas have not always been encouraging.

The U.S. Office of Economic Opportunity has funded experimental neighbourhood health centres for the purpose of developing health care at many different levels - medical care for sick individuals, employment or voluntary work for indigenous workers who wish to become intermediaries between professionals and local people, and opportunity for consumers to participate in management and learn the skills of committee work in a democratic society⁽²⁶⁾.

It seems likely that animation sociale may have greater success in Quebec than in the provinces with an Anglo-Saxon tradition. In Quebec, there appears to be strong public support for the Government's attempts to change the present social system. In some of the western provinces the public has been clearly resistant to change and shows greater inertia. Clashes have occurred between community development officers and governments over the speed of change. The different reasons for this are explored in Chapter 9, Canadian Objectives and Health Care.

CHARACTERISTICS OF HEALTH CENTRES

The evidence suggests the following as significant characteristics of successful health centres.

1. that each centre is part of a total system of health care with each part linked to the others;
2. that the centre emphasizes surveillance, maintenance and restoration rather than diagnosis and treatment only;
3. that it incorporates diagnosis and treatment into a continuing care service;
4. that one major objective is to keep people out of hospitals;
5. that health professionals work in teams in health centres, (although the concept of a team is unclear);

6. that there must be a good planning of organization structures - restrictive administrative boundaries may hinder full development of the concept;
7. that there may be several different kinds of sponsorship - that of consumers, providers, educational bodies and governments - and sponsorship is likely to affect the objectives and the organization of the centre;
8. that consumer boards may or may not be closely linked to the community;
9. that sufficient incentives exist for physicians to want to work there.

Community health centres are special kinds of health centres which:

1. stress "whole patient medicine" which implies concern about psychosocial need and continuing care,
2. emphasize family practice,
3. attempt to counter urban (or rural) alienation from the national society. One of the means to this end is to emphasize community involvement. This may be achieved by community development programs of animation sociale,
4. differ from the traditional doctor's office of group practice model,
5. depend upon a satisfactory communication system for the sifting of problems and careful referrals to the appropriate professionals.

THE NEED FOR SYNTHESIS

Reviewing international developments, Badgley⁽²⁷⁾ says, "Whether introduced before or after the initiation of national health legislation, in many western countries the creation of community health centres has been: (1) largely a state rather than a private sector innovation; (2) in principle often opposed by the medical profession; (3) tried initially on an experimental

basis; and (4) established in settings in which few services are then being provided (e.g. rural areas, ghettos...)

Roemer (28) argues that health centres are being proposed as the antithesis to the overemphasis on specialization which has characterized medical care in the western countries, and he does not think that they can succeed unless they become part of an organized health care system. His international over-view suggests that the place to begin is with regional planning.

The medical profession is likely to resist change. Financial incentives may have to be used to encourage their interest in working in health centres.

SUMMARY

Health centres have been developed in many countries to provide primary care. These centres may be for preventive, curative or integrated care: they may offer a general service or cater to specific groups; they may offer primary care only or additional multi-specialty services.

They are not likely to be lastingly or thoroughly successful unless they are linked into a total system of continuing care.

The Soviet Union developed an integrated three-tiered equitable system in the 1920's because it disregarded the entrepreneurial interests of physicians.

In the United States, Health Maintenance Organizations have recently been proposed as a middle-group solution to the present problems of health service financing. These Health Maintenance Organizations have four characteristics: an organized delivery system; an enrolled population; a financial plan which includes hospital care, and a managing organization.

In Great Britain the integrated National Health Service has been developed incrementally out of an entrepreneurial system. But despite early planning for health centres it has been difficult to convince general practitioners that they should practice in them and a number of financial incentives have had to be provided.

Health care is not the same as medical care. A health centre set up in South London in 1935 emphasized annual checkups, family membership of the centre and recreational activities, in an effort to combat urban alienation, but the centre failed to survive after the National Health Service was introduced because it did not include curative services.

There are different approaches to the provision of health care. Two models are discussed. In the first, three types of medical practice are shown, specialists at the top of the pyramid, family physicians interested in solving individual problems and using supportive teams lower down, and lower still the physicians concerned with society's problems as well as individuals.

Four states of development in medical education in the United States and Canada have been identified. The final phase beginning in 1969 emphasizes community medicine. While family physicians' status position is still being developed within the profession, there has recently been greater recognition of their efforts.

The second level of the model emphasizes teamwork. Health sciences centres are being developed in universities to co-ordinate training together of health professions. But the concept of teamwork conveys different ideas to different professions. New speaks of "cognitive dissonance". The concept will be difficult to work out in practice but it is the only concept which is basic to all health centre models.

Health care teams may not require physicians. Personnel in the team should be appropriately chosen for the functions they are to perform.

A model proposed by the psychiatrists and sociologists begins by looking at people in the community and their problems. Most people are able to cope with living most of the time but when they have problems they may not know how to get help, particularly how to find their way into the professional help-giving system. Problems may become wrongly labelled and so the wrong profession may be asked to help. Many problems may be labelled "medical problems" when they could be solved by others, professional or non-professional. The medical model is wasteful of skilled manpower. A chart showing the levels of intervention demonstrates that friends may refer to case finders and they in turn to professionals who can diagnose and treat in the community. Few will

need to have semi-protective or total care. This model provides for medical crisis care and speedy return to the community. It presupposes willingness of physicians to delegate work that can be done by less qualified people. Unfortunately at present they are not very good at delegating.

The development of community support rests on the willingness and ability of communities to take responsibility for their members. Community development or animation sociale is proposed as a method of getting them to do so.

In the United States, Neighbourhood Health Centres have been financed with the obligation to have community participation by patients as part of the therapy for sick (deprived) communities. Different types of deprived communities may react in different ways to their problems. Different provinces may be more interested in animation sociale than others. Reasons for this are explored later.

The characteristics of successful health centres and community health centres are outlined.

Neither health centres nor community health centres are likely to succeed without regional planning.

REFERENCES

1. Roemer, M.T.: Evaluation of Community Health Centres. Unpublished document, U.C.L.A., 1970.
2. Wallace, J.D.: General Secretary, Canadian Medical Association: General Impressions - Trip to U.S.S.R., unpublished document June/July, 1971.
3. Great Britain Ministry of Health, Consultative Council on Medical and Allied Services, Interim Report on the Future of Medical and Allied Services H.M.S.O. London, 1970.
4. Milton Terris: Hermann Biggs' Contribution to the Modern Concept of the Health Centre, Bulletin of the History of Medicine, 20 (3) 1946, p. 387-412.
5. Information provided by Dr. J. Blanpain, Director of the School of Hospitals and Health Care Organization, University of Louvain, Belgium.

6. Evolution des Centres de Santé et Organisation Sociale de la Médecine (III Congress National des Médecins de Centres de Santé - Soins et Prevention), Supplement au Centre de Santé avril 1964.
7. McColl, W.A.: Group Practice and Prepayment of Medical Care. Washington Public Affairs Press, 1966.
8. Health Insurance Plan of New York: Annual Reports. 1971.
9. Greenlick, Merwyn R.: The Impact of Prepaid Group Practice on American Medical Care. A Critical Evaluation. Kaiser Foundation, Portland, 1971.
10. Klein, Rudolf: Notes Towards a Theory of Patient Involvement.
11. Pearson, R.J.C.: Health Maintenance Organizations.
12. Mott, F.: Personal Communication.
- 13a. Eckstein, H.: Pressure Group Politics. London, Allen and Unwin, 1960.
- 13b. Great Britain: Ministry of Health: Report of the Review Body on Doctors Pay, 1966.
- 13c. Great Britain: Ministry of Health: The Field of Work of the Family Doctor, 1963.
- 13d. Great Britain: Ministry of Health: Health and Welfare: The Development of Community Care, H.M.S.O., 1963.
- 13e. Wofinden, R.C.: Health Centres: Problems and Possibilities. Community Medicine, Sept. 24, 1971. p. 175-178.
- 13f. Great Britain: Report: Royal Commission on Medical Education. H.M.S.O., 1968.
- 13g. Great Britain: Ministry Circulars on Administrative Arrangements of Health Centres, 1969-71.
14. Pearse, I.H. and Crocker, L.H.: London Pioneer Health Centre The Peckham Experiment. Allen and Unwin, London, 1943.

15. Delva, P.L.: The Concept of Family Practice - The Future: Continuing Family Care.
16. Papers and summaries of Community Health Centre Project seminars:
 - (a) Evans, George: Community Health Care - Manpower Considerations.
 - (b) Smith, Neville: Ambulatory Health Care - The Views of a Clinic Physician.
 - (c) Greenhill, Stanley: Summary: Seminar, Physicians' Services.
 - (d) Kergin, Dorothy: Nursing: Community-Related Personnel, Attitudes and Projects.
 - (e) Splane, Verna H.: Summary: Seminar, Physicians'
 - (f) Hall, Oswald: Allied Health Professionals in Community Health Centres.
 - (g) Crichton, Anne: Summary: Seminar, Services of Allied Health Personnel.
 - (h) Bachynsky, J.: Background papers: Pharmaceutical Services.
 - (i) Hlynka, J.N.: Summary: Seminar, Pharmacy Services.
 - (j) MacFarlane, B. and Reid, A.: The Dentist, Dental Practice and the Community Health Centre.
 - (k) Hunt, A. Murray: Summary: Seminar, Dental Services.
 - (l) Ghan, Len: Social Work Practice in Community Health Centres.
 - (m) MacKenzie, John A.: Summary: Seminar, Social Work Services.
 - (n) Griffith, F.H.: Health Centre Administration.
 - (o) Crichton, Anne: Summary: Seminar, Administrative and Managerial Services.

- (p) Chase, Malcolm I.: Some Administrative Problems and Experiences of a Business Manager in a Regional Multi-Specialty Clinic - Part I - External Affairs, Part II Internal Affairs.
- (q) Crichton, Anne: Summary: Manpower Seminars.
- (r) Schwenger, C.W.: Public Health and Community Health Centres.
- (s) Denhez, Julien: Summary: Seminar, Public Health Services.
- (t) Coates, Donald B.: Mental Health Aspects of Primary Health Care.
- (u) Ives, G.A.: Summary: Seminar, Mental Health Services.
- (v) Roth, F. Burns: The Relationship of Hospitals to Community Health Facilities.
- (w) Rosenfeld, G.B.: Summary: Seminar, Hospital Services.
- (x) MacKinnon, F.R.: Social Service Delivery System.
- (y) Clarkson, Graham J.: Difficulties and Advantages of Amalgamation.
- (z) Crichton, Anne: Social Policies.
- (aa) Morgan, J.S.: Summary: Seminar, Social Policy and Social Services.
- (bb) Houghton, James: Citizen Involvement in Health Affairs.
- (cc) Crichton, Anne: Summary: Citizen Involvement.
- (dd) Crichton, Anne: Seminar: Citizen Involvement.
- (ee) Ogrodnik, T.: Summary: Seminar, Design Aspects.
- (ff) Ruderman, A.P.: Summary: Seminar, Cost and Financial Aspects.

17. College of Family Physicians of Canada: A Submission to the Expert Project Committee, Community Health Centre Project, Jan., 28, 1972.
 18. Funkenstein, D.A. Medical Students, Medical Schools and Society during Three Eras. Paper given at Bowman Gray School of Medicine, Winston Salem, N.C., June 25, 1969.
 - 19a. Detwiler, L.F.: Health Sciences Centres. Hospital Administration in Canada, 1962-5. Feb., 1963, pp.35-38, March, 1963, pp.48-50, April, 1963, pp.52-57, May, 1963, pp.53-58, June, 1963, pp.63-65, July, 1963, pp.60-62, Aug., 1963, pp.63-66, Sept., 1963, pp.54-60, Oct., 1963, pp.62-65.
 - 19b. Szasz, George: Education for the Health Team. Canadian Journal of Public Health No. 5, Sept.-Oct. 1970, pp.386-390.
 - 19c. Larsen, Donald E.: Education of Personnel for Primary Health Care.
 20. New, Peter, Kong-Ming: An Analysis of the Concept of Teamwork. Community Mental Health Journal, Vol. 4. (4), 1968.
 - 21a. Scheff, Thos. J.: Being Mentally Ill. Aldine, New York, 1971.
 - 21b. Scheff, Thos. J.: Mental Illness and Social Processes. Harper and Row, New York, 1967.
 22. Bean, Irwin W.: Group Practice in the 70's. Canadian Family Physician, April, 1971.
 23. The Commission on Emotional and Learning Disorders in Children: One Million Children. L. Crainford - Toronto, June, 1970.
 24. Warner, Morton M.: An Analysis of Norms of Operations of Family Physicians and their Patients: Implications for Developments in Training and Community Existence. Preliminary report. The College of Family Physicians of Canada, B.C. Chapter, Research Committee, mimeographed, April, 1972.
 25. Houghton, James G.: Citizen Involvement in Health Affairs.
- Crichton, Anne: Summary: Seminars, Citizen Involvement in Health Affairs.

- 26a. Kramer, Ralph M.: Participation of the Poor: Comparative Community Case Studies in the War on Poverty. Englewood Cliffs, N.J. Prentice-Hall, 1969.
- 26b. Spiegel, Hans,: B.C. ed. Citizen Participation in Urban Development. Centre for Community Affairs, National Training Laboratory Institute for Applied Behavioural Science, Washington, D.C., 1968.
- 26c. Moynihan, Daniel P.: Maximum Feasible Misunderstanding: Community Action in the War on Poverty.
- 26d. Altshuler, Alan A.: Community Control: The Black Demand for Participation. Pegasus, Division of Bobbs-Merrill Co., New York, 1970.
- 26e. Hollister, Robert N.: From Consumer Participation to Community Control of Neighborhood Health Centres. unpublished, Massachusetts Institute of Technology, Cambridge, Mass., 1971.
- 27. Badgley, Robin F.: Health Centres: An International Comparison of Trends and Issues.
- 28. Roemer, M.I.: Organized Ambulatory Health Services in International Perspective. International Journal of Health Services, Vol. I, No. 1, 1971.

SOME CONCEPTUAL DIFFICULTIES

COMMUNITY

What is meant by 'community', especially in the context of community health centre?

Bell⁽¹⁾ points out that there are multiple dimensions in the concept of community including the following:

1. "Territorial meaning. The community is sometimes thought of in terms of a specific geographical entity, defined by natural boundaries.
2. Administrative meaning. Community sometimes refers to administrative-political units. Usually, such units are differentiated on the basis of historical and/or political factors.
3. Social psychological meaning. A very common meaning of community is that it is an entity which is defined by the shared meanings of people who identify with a particular locality, or shared interests and concerns. Thus, the community bounded by 'we-feeling' may or may not be territorial in administrative referent.
4. Social structural meaning. A few sociologists seem to locate the meaning of community at a level of the set of relationships and institutions. In their view, the community is more abstract, being the set of social arrangements that exists. This may or may not correspond with the above meanings.
5. Information environment meaning. A more uncommon usage is at least implicit in recent writings. This approach would see the community as bounded by communication. Technological innovation may produce a "global village" by operating shared information environments."

Bell continues: "It is a term used popularly and widely... It has a variety of surplus connotations as well as specific connotations. Part of the reaction to the use of the term in relation to health care stems from these emotional overtones rather than its specific referents. To many, the term 'community' is a good

thing, something which we once had in a simpler, more organic stage of social development, but which was eclipsed by urbanization, industrialization and technological process. For others, the term seems to have an opposite colour: 'community' smacks of communism, the welfare state, disrespect for authority, etc. As an adjective, 'community' is an emotionally loaded word and the loading can be very different".

There is no doubt that this is true. In Saskatchewan, some physicians spoke of the community clinics as 'the Comie Clinics' and their association with the Cooperative Commonwealth Federation (CCF)/New Democratic Party (NDP) was emphasized (2). In Ontario the St. Catharines and the Sault clinics were set up by unions. In Manitoba an NDP government has been pushing for the establishment of community health centres. The image of a community clinic or health centre in Canada tends to be left-wing, radical, activist - a challenge to existing institutions. Yet this is not the image of community mental health centres, for they are seen to be agents of social control coping with the disturbed elements in the community.

"Sociologists have been unable to discover any stable central meaning to the concept of 'community'", says Bell. "In the hands of administrators and planners, the meaning (of the term) may shift imperceptibly, depending on the issue at hand. Another complication is added by the fact that the various meanings are not fixed and may change at different rates and in response to different forces".

It would seem to be important to try to devise administrative-political units which make the best compromise between geographical, technological and social factors.

COMMUNITY INVOLVEMENT

Fish (3) argues that "without community involvement the objectives set for community health centres could not be achieved".

What is meant by community involvement? There are many ambiguities in the uses of the words community, consumers', users', citizens' or residents', patients' or clients' involvement. Most discussions do not clarify these distinctions.

Some confusion has arisen about citizens' involvement in four different roles, as volunteers, as pressure groups, as charity fund raisers and as representatives of taxpayers' interests.

TAXPAYER INVOLVEMENT

Taxpayers want to know what is happening to moneys being redistributed at all levels. There are many confusions about taxpayer involvement, because elected representatives have to respond at one and the same time to the general demands from taxpayers to keep taxes down and with the needs of the community for good social services. Elected representatives often find themselves in dilemmas because of limited resources of funds. Choice is difficult because it is not easy to measure outcomes.

INTEREST GROUP INVOLVEMENT

Citizens are well aware of the pressures they can put on their elected representatives to achieve their special purposes and there are plenty of CITIZEN PRESSURE GROUPS in the health field. These pressure groups can push hard for their special objectives. Some of the pressure is built up by traditional methods: letters to the Minister, questions by opposition M.L.A.'s, use of "hot lines", letters to the editor, T.V. interviews, particularly centred around crisis situations. But even when the governments have commitments, to clearly established and well publicized plans, the media can stir up emotions about patients said to be neglected - thus there is distortion by individuals and pressure groups in favour of the sick and against preventive activity because the results of crisis intervention makes news (e.g. in heart and renal failure cases). The complex technological processes associated with treatment are interesting to the audiences of the media and emotions are easily stirred. Most of us are afraid of death and pain and more concerned about getting medical care in emergencies than in developing the partnership of health team and patient required for long-term continuing care.

CITIZEN INVOLVEMENT

Citizen involvement has tended to be used to describe activities associated with the raising and spending of money on social service institutions. In an entrepreneurial society, citizens became involved in service club activities or other charitable money-raising efforts to help the poor and unfortunate. Gradually, in the move towards 'a political economy of health' the situation has changed. The account written by Govan⁽⁴⁾ in 1966 on Voluntary Health Organizations in Canada now seems curiously old-fashioned.

The most highly organized citizen groups involved in health care have been the hospital boards which are usually representative of the local business community.⁽⁵⁾ There are, of course, other boards of voluntary health and social institutions, part businessmen and part professionals.

CITIZEN BOARDS

Citizen Boards are now in an ambiguous position, very different from the days in which the pattern was set up because the provincial governments, with the help of shared cost grants from Ottawa, will meet the operating costs of hospitals and usually some of the costs of other institutions under the Canada Assistance Plan. Other institutions may qualify for provincial mental health grants which will meet all their operating costs.

Because established voluntary organizations may become contractors to the government, boards may become completely divorced from money-raising for operational expenditure. They may only have to consider raising money for additional capital costs, and often developmental capital for on-going institutions may be raised on low interest loans from provincial governments.

The main difficulties in money raising are encountered by boards of new and experimental institutions which find it hard to raise money from direct appeals, from the United Appeal Fund, or from municipal or provincial authorities.

CONSUMER INVOLVEMENT

Consumer Involvement has meanings which overlap to some extent with citizen involvement. These are some of the meanings:

- (a) that a members' association board has been set up to advise a prepaid group practice or medical insurance fund about its financial activities.
- (b) that a members' association board acts in a landlord-tenant relationship to a group practice.
- (c) that a members' association board advises the physicians about community demands and needs and assists the physicians in educational programs.
- (d) that a members' association board sets policies for the organization, and manages its activities.

These boards may be described as 'sponsors'.

- (e) Alternatively a consumer group may be developed by members of the public some of whom may be professionals, to publicize health demands. These groups usually have affiliations to such bodies as the Consumers' Association, the United Appeal, Cooperative or Labour Union groups, or the local branch of the College of Family Practice.
- (f) Tonkin and Szasz ⁽⁶⁾ have listed the innovative activities of less traditional organizations in British Columbia today. The problems of urban alienation and loneliness, transient youth, alcoholism, drug addiction etc. have led to the development of new services - crisis centre activities for the elderly, adolescents, and other ages; hostel and clinic services for transient youth, a rescue operation for Skid Row, and other models of practice somewhat different from the customary services offered by medical practitioners' offices. These services are often developed jointly by consumer representatives and citizens-for-consumers.
- (g) Voluntary organizations, traditionally, have worked to help powerless consumers: There is a long established tradition of voluntary work for the victims of specific

diseases such as rheumatoid arthritis, tuberculosis and other respiratory diseases, heart and stroke, and many more. Charity organizations and middle-class volunteers have had considerable importance in the development of clinics and other health services for some groups which have had little positive social power but which are troublesome to the social conscience. Their influence is still considerable. To take one example, a charity clinic was established by the Christian Medical Society in conjunction with Harbor Lights - the Salvation Army Centre - in Vancouver in 1953 and has been operating ever since. This clinic involves both private practitioners and medical student volunteers.

PATIENT INVOLVEMENT

Patient involvement has sometimes been regarded as the responsibility of professional health educators. They have not been noticeably successful at their task.

The willingness of the community, consumers, citizens, patients to play their part in keeping well is not obvious. Though there are some who observe a strict regimen, most have some weaknesses which they indulge, e.g. overeating, smoking, drinking, drug-taking, failure to take exercise. But when health breaks down, people expect to be cured. Health professionals and politicians have only just begun to question whether this expectation should always be met.

The concept of "the patient" is not unlike the concept of a person who adopts "the sick role", a deviant from the norms of society which expects people to be well⁽⁷⁾.

When the idea of health education or personal involvement in health is put more positively in terms of developing recreational and educational activities to keep people well, to stop them from becoming patients the questions which need to be answered are:

- (a) Are "consumers", "users" or "clients" different from "patients"?
- (b) To what extent should community health centres be involved in providing for the grey area claimed by many service

groups as their territory -- educationalists who are concerned with greater self-actualization, social workers who wish to improve social functioning, social activists who wish 'communities' to become more 'developed', or medical and allied health professionals who claim to offer health care? Should they be known as community centres rather than community health centres?

Klein(8) has also tried to come to grips with the semantic problems of "involvement". For if consumer involvement is, as an aim of public policy either to be encouraged or discouraged, then it is essential to know what is meant by it..."

He also says: "It is impossible to talk to the consumer of health services. There are the consumers of routine primary care. There are the consumers of acute hospital care. There are the consumers of institutional chronic care. All have somewhat different (and inasmuch as they are competing for limited resources, conflicting) interests. Even within these broad categories, further distinctions must be made. Thus, to take the consumer of a health centre, mothers of small children may attach far more importance to the ready availability of home visits than middle-aged couples. Unlike the users of a school where everyone tends to gain from improving the quality of the education the users of a health centre may have a variety of priorities".

He says, "Involvement can perhaps most usefully be regarded as a line running from professional dominance to consumer dominance, the health services coming, at present, at the professional extreme". It is then possible to distinguish between the following specific forms of involvement: (See Chart 4)

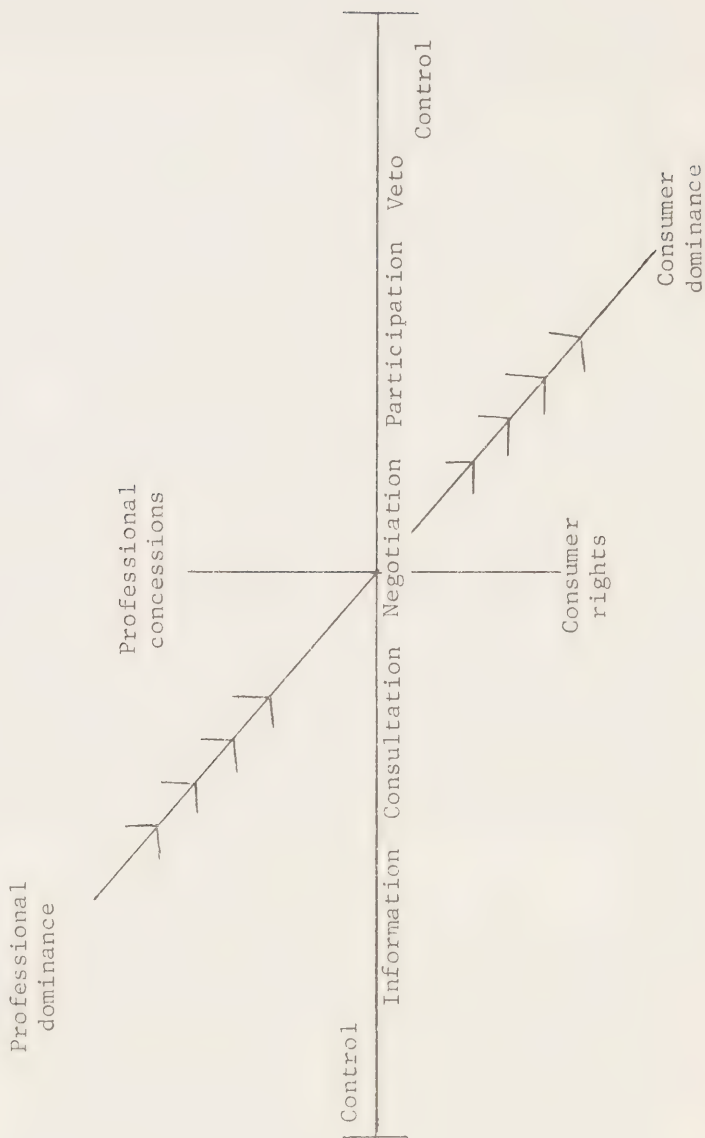
INFORMATION

The minimum form of 'public involvement' is the sharing of information about the functioning of the service. This is the weakest form of involvement. However, it is also the essential precondition for any other stronger form since without information the consumer is helpless.

VARIATION OF INVOLVEMENT IN A PROFESSIONALLY

PROVIDED SERVICE

CHART 4



CONSULTATION

Once a consumer of services (whether a patient or the parent of a schoolchild) has information, the question is what use will he or she be able to make of it. In short, will the producer of services consult the informed consumer?

NEGOTIATION

Consultation does not imply accepting the views or representations of the consumer. Negotiation, on the other hand, suggests a greater degree of equality between the parties: a bargaining situation.

PARTICIPATION

Negotiations usually means bargaining about decisions already taken by the producers; these may be modified during the negotiating process. Participation is taken to mean sharing in the decision-making process itself.

VETO

Defining participation to mean taking part in the decision-making process begs the question of the distribution of power and/or votes. Participation can therefore be used in both a weak and a strong sense. The strongest form is veto-participation: the ability, that is, to block all decisions.

THE DYNAMICS OF CITIZEN PARTICIPATION

New⁽⁹⁾ develops a discussion on citizen participation which, he says, needs to be separated "from control, involvement, decision making and advice. Each of these components are linked. One may participate without having any decision-making powers or one may participate without any power to control. At the same time, each of these components may also be seen as stages in the

total development of a community health centre. Participation may lead to control. Advisory functions of citizens may lead to decision-making powers... A major danger of citizen involvement occurs when the citizen's role is not clearly defined, but even (so)... they may wish to shift from an advisory capacity, for instance, to a policy-making one. (It would be necessary) to accommodate and tolerate these changes".

HEALTH

What is meant by health?

Kohn⁽¹⁰⁾ defined health in a paper prepared for the Hall Commission:

1. "That besides physical and mental well-being, health also implies social adjustment.
2. That even if we try to omit the question of social adjustment from our enquiry, we find that the physical, and particularly the mental aspects of health, cannot be separated entirely from social and environmental influences.
3. That there is such a thing as positive health, which is more than merely the absence of illness.
4. That we lack the means of directly measuring quantitative health, so that for the time being we must be content with measuring health defects rather than health as such."

This broad concept of health suggests that professional medical care can only go a limited way towards ensuring the good health of Canadian residents. As LeRiche⁽¹¹⁾ points out, the present measures of mortality and morbidity do not give precise enough information about health. The epidemiologist measures the prevalence and incidence of disease, but the public's view does not necessarily coincide with the physician's view of what is morbidity. In clinical morbidity surveys it has been found that there is overreporting of some diseases and underreporting of conditions which are hidden from the patient until diagnostic tests are carried out.

In recent years there has been some concern to develop more satisfactory indicators of the state of health of nations or selected groups within them. Manceau⁽¹²⁾ discussing these developments, says:

"Aujourd'hui la lutte vers un idéal de santé est bien plus complexe. Il n'est plus possible de considérer les problèmes qui se posent en termes de mortalité globale, de mortalité infantile ou de tout autre genre. Il faut tenir compte simultanément d'un plus grand nombre de variables et c'est là, justement, que résident des difficultés majeures."

In developing his argument, Manceau discusses the work of a number of epidemiologists who are concerned to relate such concepts as mortality, lost years of productive work, number of patients hospitalized, number of out-patient consultations, and days lost through indisposition, for a selected population and a control group.

Anderson⁽¹³⁾ wonders whether there is a new epidemiological model which must be considered: the adaptive ecological model in which adaptation is healthy and the system is cybernetic. The factors which influence the state of health, therefore, are the factors which cause maladaptation to the diseases of stress, social dysfunctioning, delinquency, morbidity, suicide, etc.

THE NEED FOR HEALTH CARE

"No objective need exists which determines the levels of medical care", says Boulding.⁽¹⁴⁾ "Certain minimum mechanical, chemical, biological, even economic and sociological requirements exist for the functioning of any organism or organization... Can the system itself be trusted to maintain the inputs and outputs necessary to satisfy homeostatic need, or is a professional required with a wider body of knowledge who can perceive and prescribe the homeostatic needs? Underlying this discussion is the idea of health itself... the question as to what state of the organism is to be maintained still has to be answered." This is not a question only of individual health he says, but also of societal health. "Societies can be sick even when the individuals in them are medically well."

Attempts have also been made in recent years to establish social indicators to show what is the health of a society - what are its strengths and weaknesses?⁽¹⁵⁾ Included in these are, of course, the indicators of disease, but the attempts to find appropriate social indicators which will link together facts about nutrition, housing, income, family size and so on, may tell more about health than strict epidemiological measures. Harland⁽¹⁶⁾ explains that "the social indicators movement" is an attempt to find evidence to help to answer age-old philosophical and normative questions about the quality of life in a society. "Social reporting is the process of classifying, ordering and aggregating social indicators to facilitate concise, comprehensive and balanced judgments about the quality of life."

Beaudoin⁽¹⁷⁾ suggests that in the last ten years there has been a shift in thinking about people's needs for social services: "Aujourd'hui on ne se contente plus de demander à quels problèmes tel ou tel type de programme s'adresse, mais on s'interroge plutôt sur les contributions ou l'absence de contribution que font les différents programmes à la solution des problèmes sociaux et à leur prévention de même que sur leur rôle dans le développement de notre société."

The emphasis today, he says, is upon the adequacy of social programs in preventing or solving social problems and in contributing to social development.

HEALTH CARE

Buck,⁽¹⁸⁾ an epidemiologist, draws attention to the complexity of health service objectives. She observes the quality of health care is not the same as the quality of health for:

1. "some aspects of ill health are not presently amenable to medical intervention,
2. the influence of health care upon some forms of ill health may be small in proportion to the influence of factors in the environment,
3. although many health problems are amenable to prevention or relief, the affected person may not seek care."

"Unless patient satisfaction is related to the appropriate seeking of care, compliance with care, or in some other way to the outcomes of care, it is a benefit external to quality."

Draper (19) a sociologist, has argued that it is difficult to measure the quality of care solely by looking at outcomes "because many other factors impinge on the level of health in the community, and the technological state of medicine determines the potential of health care (in the narrower sense) for improving health. Only under carefully controlled conditions might an increase in quality of care be reflected in an improved level of health."

To evaluate effective and efficient delivery of care, it is necessary (in his view) to study processes, not outcomes. His paper goes on to discuss the patient's view of health care delivery systems. "As regards the standards of organization and accommodation of a clinic, their main requirements are generally thought to be the following: a friendly and helpful reception; prompt unhurried attention to all stages of the clinic; an undivided and uninterrupted consultation, privacy, and a satisfactory level of amenity; good communication with health care personnel; a clear understanding of the advice given; compact and functional grouping of the facilities required for his visit." Within the general system of care there are complaints about accessibility and comprehensiveness, uneven quality and impersonality - lack of warmth - in relationships. Considerable dissatisfaction exists with current conditions and accommodations (crowded waiting rooms, lack of privacy, tiresome movement from one facility to another, overlong waiting periods, interrupted consultations and divided consultations when the doctor shuttles between patients, repetition of routine tests, etc., lack of help for elderly or disabled patients in dressing, inadequate communication of instructions - sometimes because of social class differences between doctors and patients, poorly organized work flows).

These unsatisfactory processes arise, Draper believes, out of unsatisfactory organization structures: "Complicated and inflexible administrative processes: shortage and maldistribution of health facilities and personnel; fragmentation of care; absence of standards for outpatient care; insufficient education of health care personnel concerning ambulatory care; poor understanding by members of the staff of the arrangements they are operating and of the standards which could be attained;

poor communication with those to be served and inadequate understanding of their demands; lack of interest in management problems as part of a heritage in which the technical medical problem is considered all important. In short, an organization structure geared to the traditional preferences and needs of health care providers, which makes it difficult to bring the health care system into alignment with the changing needs of a rapidly changing society.

This is, admittedly, a selective view. There is a clear division of opinion between epidemiologists and sociologists on what are important features of health care provision. In the past, Sackett⁽²⁰⁾ (an epidemiologist) suggests, there has been too great emphasis on process rather than health status and outcomes - reliance was placed upon unsubstantiated health professional opinion as the major tool and criterion of evaluation of health and health care. This comment is interesting in the light of complaints by consumers that there is too little concern about process.

Buck emphasizes the need to be concerned about structure, process and outcomes, and since laymen are unable to make accurate judgments themselves about the technical processes of medical care, epidemiologists can help them to evaluate outcomes. On the other hand, she agrees that it is very difficult even for epidemiologists to evaluate outcomes except for very large stable populations.

Sociologists tend to believe that epidemiologists underestimate the importance of the dynamics of structures and processes. New⁽²¹⁾ draws attention to these dynamics in discussing innovative health centres and the changing functions of the emergency room. "Even though several warnings were given some ten years ago that emergency room utilization was changing, it is only recently that we have paid much attention to some of the specific questions implied in these changes: What is the function of the emergency room? Who uses the emergency room? For what purposes are emergency rooms now used? Are these purposes legitimate or not legitimate? What character should an emergency room take on now? What is the relationship between emergency rooms and community health centres?"

He goes on to point out that there are different views of the way in which emergency rooms should be used and these different views affect patterns of supply of services and utilization. "According to the most 'legitimate' (view) patients (should only) use emergency rooms for truly emergent problems. Emergency room is a way station along a continuum of health care places, from office visits to in-patient acute hospitalization and chronic health care. Most patients who use emergency rooms, however, view them as places which offer primary care as well. Concomitantly, some physicians view these places as offices when they are not carrying out their practices in their own offices. The combination of these forces must account for a large proportion of the cases which end up in emergency rooms."

Presently, economists as well as sociologists are concerned about organizational processes, seeing that reform of processes may lead to better outcomes, as measured in terms of better productivity. Evans(22) discussed the high costs of the poor organization of professional work in a paper written for the Project.

DEMAND FOR HEALTH CARE

Field(23) has argued that there are continuing changes in biomedical technology which call for more and more allocations of capital equipment and personnel. These changes have to be approved by society and incorporated into the health care delivery system if and when society wishes to have development of facilities. Society's mandate keeps changing and new social pressures grow and they have their effect on different parts of the system. The problems of developed countries seem to be less those of examining outcomes than examining priorities and how they should be determined. We do not know what changes should be made in the organization of the present system to bring about better results in outcomes, because of lack of adequate data.

Feldstein (another economist)(24) has developed a model to explain the demand for medical care:

CHART 5

A Model of Demand For Medical Care (1)

<u>Patient</u>	<u>Physician</u>	
Factors affecting a patient's demand for treatments.	Factors affecting a physician's use of the components of care	Derived Demands for the Components of Care
Incidents of Illness	Patient characteristics	Hospital care
Cultural-demographic factors	includes relative cost to the patient from using different components of care	Physician care
Economic factors	Institutional Arrangements	Referrals to specialists, nursing home care, etc.
	Physician's knowledge	
	Relative costs to the physician from using alternative sets of components of care	

- (1) Feldstein, Paul J: Research on the Demand for Health Services.

This focuses attention upon the behaviour of the patients seeking care, the behaviour of the physicians in deciding what to do with patients and the resources available for the disposal of the patients.

As Freidson and other sociologists have pointed out (25) many barriers prevent individuals from getting into the system. But White and an inter-disciplinary team (26) have demonstrated that the same pattern of professional help-seeking occurs in eight western countries. About 20% of the population do not consult physicians.

Should more effort be made to bring people into the medical care system? Whilst there is an iceberg of disease (27), in most cases, having a disease is not synonymous with the need for treatment. LeRiche (11) (an epidemiologist) suggests that there is no need to worry about the problems of early detection of disease: "Most of the people of Canada will find medical services for conditions concerning which they have some worries and it does not seem to be a function of government or of health authorities to

start large scale and expensive schemes to discover diseases which cannot be treated and which do not particularly worry the patient."

But, if LeRiche does not think we need worry about Canadians finding their way into the system, others do. Tsalikis⁽²⁸⁾ (sociologist) suggests that, in Manitoba, a second-class service is given to the old, rural populations, the mentally ill, the poor: "What is their choice of doctor in the private market? Are they in a position to know what treatment they need?"

SUPPLY OF MEDICAL CARE

Once patients get into the Canadian medical care system, Boudreau⁽²⁹⁾ says, 90% of their care is decided by medical professionals. The reasons for this are discussed in Chapter 5 where the existing referral system is described.

CENTRES

What is meant by "centres" in the phrase "community health centres"?

Distinctions may be made between:

- (a) medical clinics,
- (b) community centres (physical structures), and
- (c) community networks of health professionals and others whose aim is to assist people to get health care.

EGALITARIAN TEAMWORK

The difference between a group practice and a community health centre lies in the willingness of the physicians in the latter to engage in teamwork with other health professionals. The team will be concerned about "whole patient medicine" and community health and so will provide more than the traditional medical consultation.

As well, the international research team found that in Canada there was more self medication than in European countries. (26) About 20% of the population do not consult physicians.

The difficulties of developing egalitarian teamwork were raised in the previous chapter. There are many aspects of 'cognitive dissonance' says New(30). "In our attempts to be too equal, we may have done a disservice to ourselves... we should realize that competence, by itself, implies a certain amount of inequality; that indeed some persons are more capable than others ... that some persons have more power and authority than others to get things done in a community... There has to be a proper mixture of the amount of information to be withheld or released and the proper utilization of the information..."

Because the members of some professional groups are more solidly entrenched they have more power. This needs to be recognized, whilst at the same time they need to give recognition to the domains of others and to be prepared to be flexible about marginal activities in going about their tasks. New suggests that:"The success or failure of the work of community health personnel, who are members of the health team, depends on an understanding of the more subtle issues that underlie the actions of the team members. Too much of the teamwork fails because of our unwillingness to bring substantive issues to the forefront and we consider only the functional rationalities..."

Hall(31) discussed some of these substantive problems in his paper for the allied health professionals seminar. The community health centres "will exhibit very complex administrative problems. These will stem in part from the small size of the organization and from the fact that there will be very small numbers of any kind of worker in the organization. The doctrines of 'team effort' and 'team decision-making' carry overtones of equality. The most troublesome administrative problem is likely to emerge at the internal level, in the relations of the various kinds of workers one to another.

These centres will experience many of the current internal tensions of hospitals, but probably in an exaggerated fashion... The patterns of control that emerge will doubtless be determined less by the skill and training of the personnel than by their capacity to seize opportunities to be of central usefulness in these new settings."

"The ancient divisions of sex and age are likely to emerge as central determinants of organization. The doctor in the centre will probably be male, and therefore assert his right to administer not only on the basis of professional dominance but also as a masculine prerogative. And because, as a doctor, he is very probably older than are the paramedical workers, his right to administer is strengthened by his age status. None of these prerogatives may sit well with those paramedical workers who have come to assume a model of "equality of team membership" as the appropriate style of administration. Moreover, whenever doctors and other male practitioners work in association with paramedicals they tend to see themselves as "men" but also they see the feminine workers not as "women" but as "girls". Doctors and dentists see their assistants as "girl Fridays" even though these assistants have long ceased to be "girls" in the chronological sense. Insofar as feminine workers are eminently attuned to the doctrine and practice of equality of the sexes, these assumptions about sex and age in the work world will make for a bumpy ride."

And, he says, since "it is hardly likely that there will be more than one physiotherapist, occupational therapist, medical social worker or laboratory technician, these workers, where present will not only be involved in a struggle for status but will be engaged in a lonely struggle. Since each worker in all likelihood will have no colleagues to whom he or she can turn for support, each is likely to strive for maximum personal autonomy. As a consequence, co-ordination will be difficult."

TREATMENT THEORIES

The question was raised earlier about the extent to which community health centres should be involved in providing for the grey area claimed by many service groups as their territory - educationalists who are concerned with greater self-actualization, social workers who wish to improve social functioning, social activists who wish communities to become more developed, or medical and allied health professionals who claim to offer health care? Should they be known as community centres rather than community health centres?

The model of a CLSC (Centre Local de Service Communautaire) proposed in Québec is a joint health and social service centre. Clients would be received at the door by workers skilled in sorting out problems and then referred to appropriate helpers,

professional or non-professional. Once accepted by the centre for care, appropriate diagnostic and treatment facilities would have to be available.

Medical services are now becoming organized into a three-tiered system of primary, secondary (specialized) and tertiary (supra-specialized) care. These three levels are normally associated with care given by the general practitioner or family physician, the specialist and the academic specialist. Whilst the care, at all levels, may be given on an out-patient basis, it is often associated with community hospitals, secondary referral centres and university teaching hospitals. In Canada, the system of referrals between the three levels is not yet efficiently organized for reasons which will be explained in the chapter on the existing system of medical care. This system is linked to the increasing levels of complexity of biomedical technology.

There is a difference between the professional medical approach and the professional social service approach.

Kohn and Radius (32) draw attention to the problems the United States has had in trying to provide health services in poverty areas: "the basic approach to the health centre idea has differentiated between the health worker and the social service worker. The former emphasizes the medical care aspect, accepting social services as a necessary adjunct. The social worker, however, bases his expectations on matters of income maintenance, housing and sanitation with the medical services but one in a range of community services. The latter approach, adopted in the United States, for example, by the OEO, has proven effective in filling immediate needs. Its disadvantage is in creating a double standard of health care: health services for the poor are poor health services. This already has been the experience of a health centre in Washington, D.C., which is now trying to relocate in an area where it hopes to attract both those who are able to prepay and those who are not."

Another kind of treatment theory which is important to understand is milieu therapy.⁽³³⁾ In milieu therapy, treatment is given by a group of people, professional workers and others who use their skills and insights to bring about changes in those who are being helped. This is the theory underlying the use of teams in community mental health and residential treatment but the concept can be applied to other forms of community

care. As much help may be given by fellow-sufferers as by professionals. The difference between help given by professionals and others is that the professionals should be more knowledgeable and more skilled in using their knowledge.

CENTRES OF COMMUNICATION NETWORKS

It was suggested, particularly by sociologists, pharmacists and the mental health group that it was most unwise to visualize a health centre only as a clinic building with services inside the walls. It was important to consider how people find their way to the health and social services - voluntary and professional. What makes them consult a physician or a lawyer, a priest or a marriage guidance counsellor or telephone the crisis centre rather than talk to a neighbour? Often it seems to be a matter of chance that one method of problem solving is chosen rather than another.

The CELDIC Committee suggested that what was necessary was to strengthen the community's communications network so that people with problems could be helped to find their way to appropriate professional helpers or given adequate support during emotional crises.

In the second Canadian Health Manpower Conference, (34) McCreary drew attention to the success of the Crisis Centre telephone answering service manned by volunteers which seems to provide adequate help for many people who are looking for answers to their problems. However, there are other more traditional sources of support which may need to be strengthened too. The pharmacists' seminar⁽³⁵⁾ suggested that the retail pharmacists should be helped to reestablish their position as advisers to residents of local communities. Their location in dispersed retail outlets makes them accessible to most people. The public health and visiting nurses, too, are community-based but have been prevented by administrative barriers from working closely with diagnostic and treatment teams. (36) (37)

Thus, community health centres can be more than buildings in which health care is provided. They may be viewed as a system of communications which sorts out problems and channels them. The centre of the communications system network in this definition is the community health centre.

SOCIAL WORK ROLES

It is not only the physicians who have different views of the way in which they may wish to practice. Ghan⁽³⁸⁾ has outlined three positions which can be taken up by social workers in community health centres - they may act as psychotherapists (or assistant psychotherapists); they may become information givers and referral agents, or they may become social activists.

Lees⁽³⁹⁾ has described three strategies used by social activists:

1. the welfare rights movement which has a legal strategy and requires people essentially to be advocates on behalf of the poor, arguing their cause, obtaining their rights, taking the lead in "entitlement campaigns";
2. community action which involves not only obtaining present rights but taking direct collective action to obtain new rights. This strategy is to take action on some matter of common concern and then to challenge the authorities to resolve the conflict";
3. community development stresses participation as the means of achieving change without the polarization of conflict inherent in community projects where social workers and other officials are concerned with activating a community so as to channel its ideas into constructive proposals - proposals that will be broadly acceptable to the authorities.

"The community action worker is concerned with the politics of consensus." The theory underlying their activity is the conflict model, whereas the welfare rights movement is based on the structural-functional model and faith in legal processes.

Holman⁽⁴⁰⁾ is doubtful that professional community development workers can promote successful change. These social workers are, he says "controlled through a hierarchy, transmitting from level to level, values and sanctions which tend to emphasize restraint and caution - for instance, not communicating with the press or politicians, not causing offence to other departments, economy and legal eligibility..."

"Community change can occur through the efforts of institutionalized bodies with a formally organized, publicly sanctioned structure, or through the efforts of groups without formal structures and not responsible to public bodies... Only conflict strategy has any record of providing the focus which stimulates inhabitants to take control of their lives and redress the inadequacies..."

It is clear that social workers have to make difficult decisions about their objectives. They may become society's agents of social control - probation officers and welfare department employees seem to be perceived as such, though many more are actually in this position (e.g. mental health workers); they may become problem identifiers and sorters or information-givers or they may offer other forms of support; they may become advocates for individuals or groups; or they may become involved in social action whether as community development officials or social activists challenging the established system of social organization.

HEALTH CARE SYSTEMS

A fully developed health care system will provide for surveillance, maintenance (i.e. treatment and continuing supervision) and restoration of the members of that society both as individuals and as social groups.

Canada's present health care system has been described as a non-system by some observers, but this is to exaggerate. The parts are there and usually co-ordination is reasonably good so far as patients in need for treatment are concerned, but what is necessary is integration of the parts rather than co-ordination if teamwork is to be developed and economies achieved.

Some failures of the health centres described by Roemer⁽⁴¹⁾ can be attributed to their lack of integration into the total spectrum of care. Diagnostic centres are a waste of money and skilled manpower if they are not linked to treatment centres, and ambulatory treatment centres must be linked to in-patient care hospitals which in turn must be able to discharge patients back into the community using convalescent homes or hostels or

foster homes if the patient cannot return to his previous way of life at once or after a long period of rehabilitation. Hospitals are being used wastefully now.

"Co-ordination itself cannot produce positive results unless there is a parallel movement of unifying goals and professional techniques" writes Self ⁽⁴²⁾, a British professor of political science.

There are confusions about the goals of the Canadian health care system and these will be examined in another chapter. As far as professional techniques are concerned, the system is at a crossroads, for the techniques appropriate to community health care are not those which are appropriate to institutional health care. Thus techniques to be employed are also a matter of values.

What the public wants is not very clear because Canadians have not been sufficiently well-informed or articulate enough to make adequate co-ordinated statements of wants. However, there is evidence in their behaviour that they are not wholly satisfied with the present delivery system.

The evidence would suggest that the goals of the public, different health professional groups and governments are not particularly well aligned.

Systematic organization by professional administrators implies research, planning, decision-making (giving consideration to alternatives), execution and evaluation, co-ordination and control.

SUMMARY

In this chapter some definitions are discussed:

- (a) Community
- (b) Community involvement
 - (i) citizen involvement
 - (ii) citizen boards
 - (iii) taxpayers' involvement

- (iv) citizen pressure groups
- (v) consumer involvement
- (vi) patient involvement

(c) Involvement

- (i) information
- (ii) consultation
- (iii) negotiation
- (iv) participation
- (v) veto

(d) The dynamics of citizen participation

(e) Health

(f) Health care

- (i) the need for health care
- (ii) demand for health care
- (iii) supply of medical care

(g) Centres

(h) Egalitarian teamwork

(i) Treatment theories

(j) Centres of communication networks

(k) Social work roles

(l) Health care systems

REFERENCES

1. Bell, Norman: Some Thoughts on the Community in Community Health Centres.
2. Anderson, D.O. and Crichton, A.: Economies of Group Practice in Saskatchewan. Unpublished Manuscript, Univ. of B.C. 1972.

Anderson, D.O.: What Price Group Practice?

Crichton, A.: The Organization of Group Practice in Saskatchewan.
3. Fish, D.: Feasibility of Implementing the Community Health Centre Concept.
4. Govan, Elizabeth S.L.: Voluntary Health Organization in Canada Royal Commission on Health Services, Queen's Printer and Controller of Stationery, Ottawa, Canada, 1966.
5. Roth, F.B.: The Relationship of Hospitals to Community Health Facilities.
6. Tonkin, R. and Szasz, G.: Two Views of Community Health Centres.
7. Gordon, Gerald: Role Theory and Illness. College and University Press, New Haven, 1966.
8. Klein, Rudolf: Notes Towards a Theory of Patient Involvement.
9. New, Peter: Community Health Centres: Five Danger Signals.
10. Kohn, Robert: The Health of the Canadian People, Royal Commission on Health Services, Queen's Printer, Ottawa, Can. 1967.
11. LeRiche, H.: Unmet Medical Needs.
12. Manceau, J.N.: Indices de Santé. Québec Ministère des Affaires Sociales, miméographié, 1972.
13. Anderson, D.O.: Personal communication.

14. Boulding, Kenneth E.: The Concept of Need for Health Services. The Milbank Memorial Fund Quarterly, Health Services Research 11, Vol. XLIV, No. 4, Part 2, Oct. 1966, p. 202-224.
- 15a. U.S. Department of Health, Education and Welfare Indicators: U.S. Government Printing Office. (May) 1958, (Feb.-March) 1960, (May) 1961, (June) 1962, (July) 1963, (Aug.) 1965.
- 15b. Bauer, Raymond A.: Social Indicators, Massachusetts Institute of Technology Press, Cambridge, Mass., and London, England, 1966.
- 15c. Delors, Jacques: Les indicateurs sociaux, Futuribles, No. 14/20, Paris, avril 1971.
- 15d. Faushell, S. et al.: A Health Status Index and its Application to Health-Service Outcomes. Operations Research, Vol. 18, No. 6, 1970, p.1021 to 1066.
- 15e. Austin, Charles J.: Selected Social Indicators in the Health Field. Am. J. Public Health, Vol. 61, No. 8, August, 1971.
- 15f. Blanchet-Patry, Madeline: Indices de l'état de Santé de la population de Québec. Commission d'Enquête sur la Santé et de Bien-Être Social, Annexe 3, 1970.
16. Harland, Douglas: The Measurement of How Things Are: Canadian Welfare, Vol. 48, No. 2, March-April, 1972, p. 9-10.
17. Beaudoin, André: Indicateurs Sociaux: Congrès de la Fédération des Services Sociaux à la Famille, Québec, Polycopie 1971.
18. Buck, Carol: The Measurement and Improvement of Quality in Ambulatory Health Care.
19. Draper, M.: How can the Quality of Ambulatory Care be Improved?
20. Sackett, D.L.: Evaluation of Innovative Community Ambulatory Care Programmes During Periods of Social Change.

21. New, Peter: The Relationship of Emergency Services and Community Health Centres: One Perspective.
22. Evans, R.G.: Medical Productivity and Group Practice.
23. Field, Mark: Stability and Change in the Medical System in ed. Inkeles, Alex and Barber, Bernard. Stability and Change in Social Systems. Little, Brown, 1971.
24. Feldstein, Paul J.: Research on the Demand for Health Services. The Milbank Memorial Fund Quarterly, Health Services Research 1, Vol. XLIV. No. 3, Part 2, July, 1966, p. 128-166.
25. Freidson, Eliot: Patients' Views of Medical Practice. Russell Sage Foundation, New York, 1961.
26. White, Kerr L. et al: International Comparisons of Medical Care. No. 3, Part 2, July 1972, p.31.
27. Last, J.M.: The Iceberg: Completing the Clinical Picture in General Practice. The Lancet, Vol. 2, July 6, 1963, p. 28.
28. Tsalikis, George: The Patients' Freedom of Choice and the Community Health Centres.
29. Boudreau, T.: Future Requirements for Health Manpower. Report of 2nd National Conference of Health Manpower, Department of National Health and Welfare, Ottawa, 1972.
30. New, Peter Kong-Ming: An Analysis of the Concept of Teamwork. Community Mental Health Journal, Vol. 4, (4), 1968.
31. Hall, Oswald: Allied Health Personnel in Community Health Centres.
32. Kohn, Robert and Radius, Susan: The United States Experience.
33. Cumming, John and Cumming, Elaine: Ego and Milieu. Atherton Press, 1963.
34. Summing up Report of 2nd National Conference on Health Manpower. Department of National Health and Welfare, Canada, Oct. 19-22, 1971.

35. Bachynsky, John: Background paper: Pharmaceutical Services. Existing Systems of Pharmaceutical Services: the Drug Distribution System.
- Hlynka, J.N.: Summary: Seminar, Pharmacy Services.
36. Churchill, M. Pamela: The Role of the Nurse in Community Health Centres.
37. Kergin, Dorothy: Nursing: Community-Related Personnel, Attitudes and Projects.
38. Ghan, Len: Social Work Practice in Community Health Centres.
39. Lees, Ray: Politics and Social Deprivation. Social Work Today, (London) Vol. 2, No. 18, Dec. 16, 1971.
40. Holman, Robert: The Wrong Poverty Programme. New Society, March 20, 1969.
41. Roemer, M.I.: Organized Ambulatory Health Services in International Perspective. International Journal of Health Services, Vol. 1, No. 1, 1971.
42. Self, Peter: Administering Democracy. New Society, Feb.24, 1972.

THE PRESENT ADMINISTRATIVE ORGANIZATION OF THE HEALTH CARE SYSTEM IN CANADA

In all western countries, problems exist in matching aspirations and realization in health care systems. Community health centres have been advocated as one way of improving this match. Before going on to explore whether community health centres are relevant and appropriate organizations to be developed within the Canadian health care system, it is important first to discover what are Canadian aspirations and their present realization. But before looking at Canadian aspirations, it is necessary to consider the powers of federal and provincial governments to provide health care and to discuss, as well, what is being done in the private sector of the health service.

There are, says Klein, (1) two models of a health service: "the market economy model" distinguished by the fact that the distribution of resources is determined by market forces, or "the political economy model" in which the allocation of resources is centrally or politically determined. Anderson (2) suggests that there is a third model: "I believe it is inappropriate to suggest that the medical care system, in the face of medical insurance of a subsidized nature, follows, in the slightest, the rules of the market place. In Canada, the medical care system follows a subsidized entrepreneurial model, i.e. entrepreneurs in medical care delivery are encouraged by subsidies in the form of fee-for-service payments and other concessions in direct contradiction to the laws of the market place. I cannot conceive that the Canadian health care system will become a political economy model without national and provincial planning vis-à-vis the distribution of resources and the limitation of health personnel."

Under the terms of the various constitutional acts, the federal government is the main revenue-raising authority, though each province has its own combination of money-collecting devices for financing social services - some have direct taxes, some use sales tax or other indirect methods of bringing in resources, some make small charges for services. Gradually, since the depression years, Canadian governments have become more and more involved in channelling the resources which residents of the country wish to put into health services.

A municipal doctor scheme was started in Saskatchewan in the depression years and a hospital insurance plan was proposed in British Columbia in 1935 (but not carried through until after the war). It was during the post-war years that all governments became more and more committed to intervention between the public and the purveyors of health care.

Over the years, the ratio of personal discretionary expenditures of the average Canadian on health care have steadily decreased as the ratio of public expenditures from federal and provincial sources have increased.

After the public sector is reviewed, consideration will be given to what remains in the private sector.

POWERS OF THE FEDERAL AND PROVINCIAL GOVERNMENTS TO PROVIDE HEALTH CARE

The British North America Act, 1867, defined the powers of the federal and provincial governments. The provinces were made responsible for "the Establishment, Maintenance and Management of Hospitals, Asylums, Charities and Eleemosynary Institutions in and for the province, other than Marine Hospitals." The federal government's powers in health care are not clearly stated. Apart from establishing and maintaining marine hospitals for quarantine purposes and providing services for groups of a certain category - militia, military and naval service and defence personnel, federal civil servants and some native peoples, the federal government has, by custom, left the provincial governments to manage the organization of health services in their own territories.

At one stage the federal government had a number of category programs for veterans, native Indians, the blind, the disabled, etc., but recently these have begun to be phased out and incorporated into four main categories of programs for health care, cost-shared by federal and provincial governments, and a fifth program for welfare recipients - the Canada Assistance Plan. These are described in the Annual Report of the Department of National Health and Welfare⁽³⁾.

- (a) NATIONAL HEALTH GRANT PROGRAM: This program, instituted in 1948, to help the provinces in extending and improving public health services and hospital facilities, was

reviewed in 1970. During the period 1948-70, the total expenditures under this program were \$900 million.

The largest single grant has been in support of hospital construction and this grant was terminated on March 31, 1970, after each province had been given lump sum payments to their full entitlement under the provisions of the grant.

The second largest grant, the General Public Health Grant, "assisted the provinces in extending local health services for the prevention of disease and disability, in controlling environmental health hazards and in developing a great variety of health services. Since 1948, more than 53,700 health personnel have received assistance in taking training in the health disciplines. Other grants are designated for preventive and treatment services in specific areas such as mental health, tuberculosis and cancer, maternal and child care, and medical rehabilitation."

The Public Health Research Grant funded projects relating to the prevention of disease, disability or death; epidemiology; community health and medical care, operational research, environmental health, including sanitation; and the utilization of health manpower.

However, these programs, apart from the Professional Training and Public Health Research Grants, were terminated as of March 31, 1972. A new program, the National Health Grant, was established in 1969, "to stimulate research studies, service demonstrations and training activities of national importance for the improvement of health services. Eligible applicants are voluntary health agencies, universities or other qualified agencies or individuals and provinces". The grant has been gradually increased from \$1,062,000 in 1969-70 to \$4,112,000 in 1972-73.

- (b) **HOSPITAL INSURANCE:** Under the Hospital Insurance and Diagnostic Services Act, 1957, the federal government shares with the provinces the cost of providing specified hospital services to patients insured by these programs. Specifically excluded are tuberculosis hospitals and sanatoria, hospitals or institutions for the mentally ill

and institutions providing custodial care, such as nursing homes and homes for the aged. The methods of administering and financing the program in each province and the provision of services above the stipulated minimum required by the Act are left to the choice of the province.

Insured in-patient services must include accommodation, meals, necessary nursing services, diagnostic procedures, pharmaceuticals, the use of operating rooms, case rooms, anaesthetic facilities, and the use of radiotherapy and physiotherapy if available. Similar out-patient services may be included in provincial plans and authorized for contribution under the Act. All provinces include some out-patient services. The provincial plans are administered by the provincial department of health in some provinces and by a separate commission in others. To finance the plans the provinces use general revenue, sales taxes and premiums in various combinations. The federal government contributes, out of the consolidated revenue fund in respect to each province, 25% of the per capita cost of in-patient services in Canada and 25% of the cost of in-patient services in a province, multiplied by the average number of insured persons in that province. Thus, the total contribution is about 50% of the shareable cost for all Canada, but the proportion is higher for provinces where the provincial per capita cost is below the national per capita, and lower for other provinces. Contributions for insured out-patient services with respect to each province are paid in the same proportion as the contributions to the cost for in-patients.

For 1971, the federal government made the following advance payments totalling \$880,438,640:

- Newfoundland	\$ 25,284,042
- Prince Edward Island	\$ 4,957,597
- Nova Scotia	\$ 40,558,640
- New Brunswick	\$ 32,305,391
- Ontario	\$404,758,664
- Manitoba	\$ 50,498,199
- Saskatchewan	\$ 46,012,421

- Alberta	\$ 91,524,442
- British Columbia	\$102,102,435
- Yukon Territory	\$ 730,251
- Northwest Territories	\$ 1,706,558* **

Provincial hospital insurance programs, operating in all provinces and territories since 1961, cover 99% of the population of Canada.

- (c) PUBLIC MEDICAL CARE: Under the Medical Care Act, 1966-67, the federal government contributes to any participating province, one-half of the per capita cost of insured services furnished under the plans of all participating provinces multiplied by the number of insured persons in that one province, provided the plans meet certain minimum criteria (viz: comprehensive coverage, universal availability, portability and administration on a non-profit basis by a public authority). At the same time the federal government leaves the provinces free to choose the way in which their plans will be financed, e.g. through premiums, sales tax, other provincial revenues, or by a combination of methods.

In addition to the comprehensive physicians' services that must be provided as insured benefits by participating provinces, the Medical Care Act empowers the federal government to include any additional health services under terms and conditions specified by the Governor in Council. So far, such additional services are limited to certain procedures carried out by dental surgeons in a hospital setting. There is a standing commitment to provinces that the federal government will not extend shareable services without a consensus of the provinces.

* Per 1000 population; based on population estimates as at December 31, 1968.

** On January 1, 1965, contributions to Quebec under the Hospital Insurance and Diagnostic Services Act were discontinued and replaced by arrangements under the Established Programs (Interim Arrangements) Act. Payments to Quebec in 1971 under the latter legislation amount to \$335,646,204. See page 4-10 for explanation.

Provincial programs that provide health care systems (apart from those already insured under the Medical Care Act) for welfare recipients, establishing eligibility on the basis of financial need, are supported financially by the federal program known as the Canada Assistance Plan. This program provides for federal payment of one-half of the cost of personal health care services as well as welfare services. The provinces are free to make available a wide range of health care benefits.

One group of citizens that has caused some concern in recent years comprises the transient Canadians, young and old, who are not eligible for Medicare because they have not met the contributory or premium regulations of provincial agencies, nor are they eligible for welfare benefits because they do not meet the residence qualifications of the receiving province, though they may meet the requirements of a municipality. This is the largest group of people not presently able to take advantage of Medicare and the Canada Assistance Plan.

- (d) **HEALTH RESOURCES PROGRAM:** Under the Health Resources Fund Act, 1966, the federal government provides capital grants for teaching and research establishments, undertakes studies on health manpower and offers advice and consultation. The intention of the Act was "to develop resources for the training of personnel in order to reduce shortages and to meet the increase in demand likely to follow the introduction of medical care insurance". A fund of \$500 million is available over the period 1966-80, and \$216,387,348 of this has been committed by March 31, 1972, about two-thirds for training facilities and one-third for research establishments. Of the \$500 million, \$400 million is available to the provinces in proportion to their population and \$25 million is available to the Atlantic provinces for joint projects in which all four provinces participate. The remaining \$175 million has yet to be allocated.

In addition to these four main shared-cost programs, a number of other services are provided directly by the federal government: viz. information and advisory services (e.g. health statistics collection and analysis, advisory activities of the Dominion Council of Health and the Health Services and Health Programs Branch of the Department of National Health and Welfare; standard setting services of the Food and Drug Directorate and

testing laboratories; some remaining categorical treatment programs; and the health research activities of the Medical Research Council and the Defence Research Board).*

PROVINCIAL AND MUNICIPAL EXPENDITURES: The Canada Year Book 1970-71⁽⁴⁾ lists four activities in which provinces and municipalities spent large sums on health care in 1969:

Hospital care	- \$1,415 million
Other health services	- \$ 350 million
Provincial Workmen's Compensation Board (medical aid and hospitalization costs)	- \$ 62 million
Municipal government health services	- \$ 89 million (est.)

The provinces themselves provide few direct services. They have the responsibility under the BNA Act for establishing and maintaining hospitals, asylums and charities, but where possible these responsibilities have been delegated to municipalities or voluntary organizations, to hospitals and health care agencies, and to private physicians.

The provinces did develop public health services in which medical health officers and public health nurses provided an infection control and health education service to local communities, working particularly through the schools and the mothers of young children. Sometimes home nursing and home care services are also provided. The provinces may delegate authority to the larger municipalities to set up health units.

* In 1971-72 the following funds were available for research: Medical Research Council \$35,642,000; National Health and Welfare Public Health Research Grant \$4,917,000; National Health Grant \$3,264,000; Conseil des Recherches Médicales (Québec) \$855,000. The MRC grant rose from \$30,891,000 in 1969-70. The Public Health and National Health grants taken together increased from \$4,400,000 to approximately \$8,000,000 and the Quebec grant increased from \$500,000 to \$855,000.⁽⁵⁾

As well, provincial authorities provide care in mental hospitals and in community mental health centres or in institutions for the retarded and for the mentally disordered. Apart from these special institutions, the provinces do not normally own the premises in which medical treatment is given. Hospitals and nursing homes may be owned by charitable organizations or by municipalities; doctors' offices may be owned by physicians themselves, or by physicians jointly with businessmen, or by businessmen alone. Occasionally, clinics may be located in premises owned by a non-profit organization.

Because they do not own the hospitals and offices or employ the staff, the provinces have developed ways of paying for their use on a contract basis. Hospitals are normally paid per diem rates for individual patients, as agreed with the Hospital Rate Boards, though some have reached global budget agreements. Physicians are remunerated on a fee-for-service basis which takes into consideration overhead costs of premises, support staff and equipment. Exceptionally, a few medical clinics have negotiated capitation payments or global budgets with their Provincial Medical Care Commission.

Anderson⁽⁶⁾ points out that the federal government has more control over expenditure on hospitals than on medical care. "Payments under the Hospital Insurance Act (1957) require that the hospital program meet a national standard. This is not the case for the Medical Care Plan where the formal criteria (of comprehensive coverage, universal availability, portability and administration on a non-profit basis by a public authority) are sufficiently ill-defined and easy to meet that, in a sense, one could almost say, "There are no standards." This struggle for decentralization of authority is well brought out in a White Paper prepared in 1965 for the Dominion Provincial Conference where it is indicated that the provinces would not give approval to the federal government to move into the insurance field but only to transfer funds and allow the provinces to retain the insurance field to themselves..."⁽⁷⁾

Health and welfare budgets of provincial governments are usually kept separate. A case for integration has been made by Clarkson⁽⁸⁾ and for separation by MacKinnon.⁽⁹⁾ Within Health Departments themselves the Medical Care Agency is likely to be administered quite separately from the Hospital Service and this may have little connection with Public Health and Mental Health

Services. There are historical reasons for this, for each of these services was started at a different time and funded on a different system from the others.

SOME COST-SHARING PROBLEMS

The greatest financial resources lie in the hands of federal government which since 1948 has been offering a series of incentive payments to the provinces to develop health services. Now that all of the provinces have a highly developed hospital service and have begun to finance medical care for nearly all residents, the federal government is considering how it may continue to use its financial power to the greatest effect. "The proportion of government expenditures on health and social welfare taken up by health programs continues to grow: in 1961-62 such programs accounted for \$1,126 million or 30% of the total and in 1968-69 they amounted to \$2,779 million or 38%". (11)

Considerable uneasiness is arising over the lack of adequate linkage between the four main health programs. The vastly increased expenditure on health care has not yet brought dramatic changes in health outcomes. Canada is still relatively low in the world's league tables of mortality and morbidity. Klein⁽¹⁰⁾ has said about the British Health Services.

"Most discussions about how best to reform or change existing health care systems fail to attach sufficient emphasis to the fact that such systems are basically machinery for distributing or rationing scarce resources. In other words, the crucial question is who makes the decision about who gets the resources. All other questions...are secondary." However this is not true of Canada, for the Council of Health Ministers is very clear that this is the key question.

At a time when strong pressures towards decentralization are present, the role of federal government is complex and difficult. It seems clear that it has now made the principal moves towards establishing equality of funding for medical care throughout Canada, as part of its wider program for moving towards a more just society.

But the provinces are anxious to take over more responsibility for their own programs. Taylor⁽¹¹⁾ has reviewed the

uneasy federal-provincial relationships which have existed, particularly since 1965 when the provincial governments insisted on retaining contributory insurance to finance Medicare. Over the years the governments have become more and more concerned about their commitment to finance open-ended health care programs.

Discussing its tabulation of expenditures, the Dominion Bureau of Statistics explains in the 1970 Year Book:

"The relative federal declines, compared to provincial gains, in recent years, have been caused, to a substantial degree, by increasing hospital expenditures by the provincial governments augmented by the effect of the 'opting-out' arrangements made available to the provinces. Under the Established Programs (Interim Arrangements) Act, 1964-65, a province may choose to receive contributions from the federal government in the form of a tax abatement and an equalization payment in lieu of a direct federal contribution under the program. The opting-out arrangements have the effect, in this presentation, of showing an increase in provincial government expenditures while the federal fiscal payment is treated not as an expenditure but as a transfer payment. Thus, provincial expenditures on health and social welfare do not include the large sums paid or transferred to that province under the Established Programs (Interim Arrangements) Act and other fiscal arrangements. The share of the federal government in total health and social welfare expenditures by all levels of government showed a steady decline from year to year up to 1967-68 but in 1968-69 this trend was reversed." (4)

The federal government is uncertain what to do about changing the present shared-cost arrangements.

It was proposed in November 1971 that cost-sharing formulae should change, but only in the health sector. New calculations were to be made at the federal level about reallocation of health moneys, and these were not to be tied to specific programs, but to the Gross National Product, inflation, population growth and need for some development in sectors presently unserved. However, these changes were suggested in the Health sector only (i.e. medical care delivery mainly) and, in the opinion of some people, did not touch on basic health problems - nutrition, housing, education about "good health" etc. The proposals have not been accepted by the provinces

mainly because of the differences in their social policies. This difference in social philosophy is shared, to some extent by the New Democratic Party governments of Manitoba and Saskatchewan, but it is complex and difficult to describe because the working out of the social philosophies of the three governments has had to be tempered by political expediency and the mandate of the two New Democratic Party governments is much less clear than the mandate of the Quebec government.

What can the federal government do to maintain the momentum it has had in bringing about change in health care provision? An important feature of the federal proposal for new financing agreements was the provision of \$640 million over six years into Thrust Funds to assist the provinces to re-organize their health care systems and introduce some effective methods of delivery services. As well, the federal government has been developing its consultancy services so that the provinces which seek help may call upon federal experts to work out specific programs with provincial officials.

THE ELEMENTS OF THE EXISTING SYSTEM

Federal legislation and methods of allocating resources divide the system into seven sectors:

1. hospitals
2. medical care purveyors
3. public and mental health services
4. health research
5. institutions assisted by health resources funds (i.e. universities, community colleges and their clinical teaching satellite units)
6. groups eligible for assistance under the Canada Assistance Plan and other categorical plans such as DVA, Civil Service
7. the private sector.

To some extent the process of co-ordination of health services has proceeded quite a long way since 1948, but, says Roth⁽¹²⁾ "While one can argue for the proposition that a national system of planning for the total use of health resources should be operative, the facts are that our society has not to this date been able to effectively plan in this manner. In the hospital

field the development of overall planning schemes are of relatively recent vintage and the implementation has not been marked with outstanding success."

Roth continues: "The first major attempt to plan a hospital and health service system in Canada dates back to the 1948-51 period when, as part of the National Health Grants program, each province was charged with the responsibility of conducting a health survey and the creation of a master plan. All provinces were able to develop a master plan for hospitals and to a more limited extent for other health services. This, in my view, is a useful procedure but the realization of the concepts of an integrated co-ordinated hospital system has not been achieved..."

He believes that planning councils have failed to achieve much in the past because "Local pressures for hospital facilities and services continued in many situations and locales with a consequent result at odds with the prescribed plan". He goes on to argue that: "One can imagine a system in which there was a single management, financing and control of all these elements of the present system... It is doubtful, however, whether this would be advisable in a society such as ours which puts stress on community participation and involvement of autonomous voluntary groups of citizens and a traditional belief in pluralism with the attendant capacity to grow, innovate and enhance through a variety of approaches..."

The system is pluralistic and attempts at planning have not so far been very successful, though there is some degree of co-ordination. Would a provincial system under a single management lose the capacity to grow and innovate?

SUMMARY

Two models of a health service, the market economy model and the political economy or government-organized model tend to be contrasted by health care system analysts. Canada has a third model - the subsidized entrepreneurial model - which has developed out of negotiations between the federal government the province and the medical profession.

In the post-war years the federal government has developed four major programs for redistributing taxes back into health services: National Health Grant Programs (for improving provincial public health and hospital services 1948-1970 - now terminated - and for financing research and professional training); Hospital Insurance; Public Medical Care; Health Resources Program (capital grants for teaching and research establishments, manpower studies).

The provinces have responsibility under the British North America Act for establishing and maintaining hospitals, asylums and charities, but in many cases they have delegated this responsibility to voluntary agencies or municipalities. Most services are provided on contract or with grant aid, though the provinces have developed a few of their own services particularly in public health and mental health.

The federal government has developed formulae for sharing the cost of services with the provincial governments in the four programs listed above. The costs of welfare programs are also shared under the Canada Assistance Plan. There are clearly-established national standards which hospitals have to meet for cost-sharing eligibility but the standards in public medical care are ill-defined. Some provinces have put health and welfare services under one Minister, others have chosen not to do so.

Considerable uneasiness has arisen about the categorical nature of shared cost programs because no dramatic change in health outcomes has occurred and the demand for more money to finance health services continues to rise. The federal government is attempting to develop new methods of cost sharing but the provinces have not yet agreed to proposed changes.

Despite federal involvement in funding since 1948 it was not until 1969 that questions began to be asked about receiving value for money in health services. In 1971 the Community Health Centre Project was set up to examine whether community health centres might help to curb costs and provide a more effective means of delivering health care.

Federal legislation and methods of allocating resources divide the existing system into seven sectors: hospitals, medical care purveyors, public and mental health services, health research, teaching institutions, categorical groups eligible under special plans, and the private sector.

The system is pluralistic and attempts at planning have not so far been very successful, though there is some degree of co-ordination. Would a provincial system under a single management lose the capacity to grow and innovate? It has been suggested that pluralism increases the adaptability of the system.

REFERENCES

1. Klein, Rudolf: The Political Economy of National Health, Report from London, The Public Interest, Winter 1972.
2. Anderson, D.O.: Personal communication.
3. Canada: Department of National Health and Welfare, Annual Report, Ottawa, 1971.
4. Canada: Dominion Bureau of Statistics, Canada Year Book, Ottawa, 1970-71.
5. Canada: Science Council, Progress Report on Health Services Research, Unpublished, Ottawa, April 1972.
6. Anderson, D.O.: Personal communication.
7. Canada: Federal - Provincial Conference, Proceedings, Queen's Printer, Ottawa, 1965.
8. Clarkson, Graham J.: Difficulties and Advantages in the Amalgamation of Health and Welfare Services.
9. MacKinnon, F.R.: Social Service Delivery Systems.
10. Klein, Rudolf: Resources, Priorities and Planning in the British NHS.
11. Taylor, Malcolm G.: The Canadian Health Insurance Program. Unpublished manuscript, York University, Toronto, 1972.
12. Roth, F.B.: The Relationship of Hospitals to Community Health Facilities.

THE EXISTING SYSTEM: A. THE HOSPITALS

FEELINGS ABOUT HOSPITALS

Hospitals are symbols of community care. They provide a security blanket for isolated and, with the improvement of transportation systems, less isolated communities in Canada.

They provide potent material for political controversy and the politicians find it hard to resist organized, emotional community groups who are determined to keep local hospitals open. This is an international phenomenon.

It appears to be politically impossible to close hospitals once they have been opened because they are centres of employment and focuses of business for small towns. (The Saskatchewan experience seems to indicate that hospitals can only be 'closed' when they are still, theoretically, able to be reopened when the community can attract a doctor. The Saskatchewan Hospital Services Plan budgets each year for several hospitals which cannot find a doctor).

Presently, hospitals are co-ordinated by a number of different mechanisms - some of which are effective and some not. Roth(1) says these vary from a planning function which has been mandated by a government directive (as in B.C.) to voluntary groupings of interested people into an agency supported in whole or in part by funds from government... At the present time the authority of these councils varies from providing approval which is accepted as being mandatory by provincial governments, to no authority to command or approve but merely to comment and recommend. At this moment the trend would appear to be to give more authority to these regional planning councils.

The amount of independence hospitals have 'is vague and hard to identify'(2). Administrators and physicians guard their autonomy carefully and they do not like to have any limits set on their freedom of choice by co-ordinating bodies.

TABLE 1. Number of Operating Hospitals and their Bed Capacities, by Type of Hospital and Province, 1972

Type and size of hospital	Canada						P.E.I.		N.S.		N.B.		Qué.		Ont.		Man.		Sask.		Alta.		B.C.		Yukon		N.W.T.			
	No.		Beds		N	Lits	T.N.		I.P.E.		N.B.		Qué.		Ont.		Man.		Sask.		Alta.		B.C.		Yukon		N.W.T.			
	No.	Beds	No.	Beds			No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds
1 All hospitals	1,422	214,296	49	4,032	12	1,092	57	7,490	43	5,209	295	61,555	363	72,247	113	10,116	150	9,954	163	19,584	130	21,370	6	160	41	487	Ensemble des hôpitaux	1		
2 Public	1,185	200,939	49	4,032	12	1,092	54	6,932	42	5,097	227	57,050	276	68,125	93	9,312	147	9,838	155	16,662	123	19,750	—	—	7	237	Publics	2		
3 General and allied special	1,049	139,515	47	2,982	9	744	47	4,798	39	4,313	188	27,375	228	48,550	84	6,275	141	7,607	145	14,054	113	13,207	—	—	7	237	Général et Spéciaux divers	3		
4 General	861	115,732	33	2,471	8	714	43	4,269	37	4,214	127	24,782	189	42,259	79	5,090	133	6,678	116	10,859	90	11,556	—	—	7	237	Général	4		
5 1-2 beds	215	33,315	12	199	2	34	14	200	8	99	10	178	5	96	44	695	80	1,139	24	397	15	256	—	—	1	22	1 à 24 lits	5		
6 25-49 "	194	6,698	10	339	1	26	5	164	9	331	12	434	31	1,197	16	534	30	986	47	1,550	27	922	—	—	6	215	25 à 49 "	6		
7 50-99 "	146	10,188	3	181	2	106	11	832	7	528	19	1,360	40	2,934	11	846	9	624	29	1,772	15	1,005	—	—	5	100	50 à 99 "	7		
8 100-199 "	124	16,695	5	768	2	321	18	1,145	6	737	36	4,731	37	4,958	2	240	6	792	5	676	17	2,327	—	—	100	100 à 199 "	8			
9 200+ "	182	78,836	3	984	1	227	5	1,928	7	2,519	50	20,672	75	33,074	6	2,775	8	3,137	11	6,474	16	7,046	—	—	200+	200+	9			
10 Allied special	188	23,783	14	511	1	30	4	329	2	105	61	936	7	6,291	5	1,185	8	929	29	3,185	23	1,651	—	—	Spéciaux divers	10				
11 Children's	8	3,085	1	280	—	1	324	—	—	2	1,184	1	7	834	1	83	—	—	1	406	5	354	—	—	Hôpital pour enfants	11				
12 Convalescent Rehabilitation	22	2,343	1	56	1	30	2	96	1	20	3	471	7	686	1	224	—	—	1	128	1	128	—	—	Convalescent Rehabilitation	12				
13 Chronic/Extended care	105	15,128	2	86	—	—	—	—	1	85	47	6,417	19	4,294	3	729	—	—	25	2,743	8	1,044	—	—	Maladies chroniques/ Soins prolongés	13				
14 Other	53	3,227	10	89	—	—	—	—	1	109	—	9,125	14	457	—	—	8	939	2	178	9	170	—	—	Autres	14				
15 Hospital for psychiatric disorders	112	58,516	1	827	2	318	5	1,782	3	1,590	33	19,513	39	18,666	8	2,894	4	2,053	9	4,503	8	6,370	—	—	Hôpitaux pour troubles psychiatriques	15				
16 Alcohol	19	750	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Hôpital pour alcooliques	16				
17 Aged and senile	4	1,668	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Hôpital de repos pour personnes âgées et vieillards	17				
18 Emotionally disturbed children, Epilepsy	3	120	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Hôpital pour enfants souffrant de troubles émotifs	18				
19 Hospital for retardates	28	17,500	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Hôpital pour épileptique	19				
20 Mental	47	36,308	1	827	1	297	4	1,187	2	1,350	15	14,544	15	11,029	2	1,448	2	638	4	2,090	1	2,898	—	—	Etablissement pour maladies mentales	20				
21 Psychiatric	9	1,503	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Etablissement psychiatrique	21				
22 Tuberculosis	24	2,908	1	223	1	30	2	352	—	6	795	8	909	1	143	2	178	1	105	2	173	—	—	—	Tuberculeux	22				
23 Private	142	5,446	—	—	—	—	—	—	—	1	51	59	3,023	74	2,321	3	80	—	—	—	—	—	—	—	—	Privés	23			
24 General and allied special	129	4,509	—	—	—	—	—	—	—	1	5	58	2,963	63	1,414	3	80	—	—	—	—	—	—	—	—	Général et Spéciaux divers	24			
25 General	30	842	—	—	—	—	—	—	—	1	5	14	344	9	216	2	30	—	—	—	—	—	—	—	—	Général	25			
26 Conv. rehab. and chronic/extended care(1).	93	3,439	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Conv. Readapt. et soins chron. et prol(1).	26			
27 Other	6	228	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Autres	27			
28 Hospital for psychiatric disorders	13	1,037	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Hôpitaux pour troubles psychiatriques	28			
29 Alcohol	1	70	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Hôpital pour alcooliques	29			
30 Emotionally disturbed children	3	81	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Hôpital pour enfants souffrant de troubles émotifs	30			
31 Hospital for retardates	5	446	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Hôpital pour atarides	31			
32 Mental	1	110	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Etablissement pour maladies mentales	32			
33 Psychiatric	3	330	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Etablissement psychiatrique	33			
34 Federal	95	7,811	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Fédéraux	34			
35 General and allied special	95	7,811	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Etablissement psychiatrique	35			
36 General	27	6,497	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Général et Spéciaux divers	36			
37 Conv. rehab. and chronic/extended care.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Conv. Readapt. et soins chron. et prol.	37			
38 Other	68	1,314	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	Autres	38			
39																														

(1) Includes 31 contract nursing homes in Ontario with 603 beds

(1) Comprend 31 foyers approuvés en Ontario avec 603 lits.

(2) Compend Institute of The Study of Addiction.

Frederick Institute of Technology

THE UNCERTAIN FUNCTIONS OF HOSPITALS

The objectives of a country's hospital service are nowhere well defined, says Logan et al.⁽³⁾, and Klein⁽⁴⁾ points out that it is much easier to count beds and occupancy rates than to measure the quantity and quality of work being done in a hospital.

The demand for hospital care varies from place to place. Different cultures have different beliefs about family responsibility for their sick members,⁽⁵⁾ and families have different resources which they may use to help their sick members.

The supply of hospital beds in Canada varies from place to place and there are considerable difficulties in getting into hospitals in metropolitan centres compared with rural hospitals.

The number of bed capacity of hospitals in Canadian provinces per 1000 population is given in Table 1, but it does not show the distribution of hospitals by size.

Canada has many very small hospitals which are neither economic to run, nor technologically high in standard. Canadians have obviously considered it to be more important to have a local hospital than an economic or high quality hospital service. Attitudes may now be changing a little but, if so, the change is slow.

As the summary of the seminar on relations of community health centres to hospitals⁽⁶⁾ reports: "Any questioning of the status quo was interpreted as an attack on hospitals... The concept held by many was that if hospitals were given the needed funds to meet the objectives of better distribution of medical care, undoubtedly the objective would be achieved."

Logan et al., contrasts the Canadian system of admission to hospitals with the British, Polish and Yugoslav systems. In these systems "social policy gives higher priority to care in the community than to care in institutions. Except in an emergency the patient can only gain access to the specialist or hospital bed through his family doctor. This represents a 'closed' system... In the 'open' systems (Canada is included in these) the individual is free to by-pass the primary care physician or general practitioner and go directly to the secondary level of the specialist."

The free choice of physician enables Canadians to put pressure on their physicians to admit them to hospital rather than to treat them on an out-patient basis.

The Saskatchewan doctors made it clear to Anderson and Crichton⁽⁷⁾ that when beds were vacant it was often difficult to resist pressure from patients to fill them.

There are too many acute care beds in Canada: Armstrong⁽⁸⁾ and Anderson⁽⁷⁾ have both been concerned to analyze the incidence of surgery and particularly elective surgery in Canada. Armstrong says: "The figures suggest that changes in bed supply tend to have a somewhat greater effect upon surgical rates than changes in the numbers of surgeons." And where there are more surgeons there is more surgery.

The present methods of financing encourage hospitals to keep the beds full and to deal with as many short-term cases as possible on an in-patient basis, although some experiments with out-patient care (e.g. day surgery) have been made.

The lack of co-ordination between diagnostic services given outside in the community and those given in hospital means that hospitals for their own legal protection, have to retest many patients who might be dealt with more speedily if diagnostic tests outside hospital could legally become part of their system of information.

Greenhill⁽⁹⁾ draws attention to the difference in hospitalization patterns in the different provinces of Canada.

"The major factor contributing to the provincial variations shown in Table 2 is the volume of care provided to those 45 years and over. As can be seen from Table 3, older people (+65 years) are institutionalized to a far greater extent in the Western than in the Atlantic regions of Canada. These regional variations are again a probable reflection of regional differences in the geo-political, socio-economic and cultural background and history of the two areas."

TABLE 2

TOTAL PATIENT DAY RATES PER 1000 POPULATION
BY PROVINCES 1965*

	<u>Canada</u>	<u>Nfld</u>	<u>N.S.</u>	<u>P.E.I.</u>	<u>N.B.</u>	
Rates	4609	2796	3862	4527	4308	
Rank		10	9	6	7	
	<u>Quebec</u>	<u>Ontario</u>	<u>Man.</u>	<u>Sask.</u>	<u>Alta.</u>	<u>B.C.</u>
Rates	4241	4754	4982	5176	5424	5010
Rank	8	5	4	2	1	3

* Task Force Reports on the Cost of Health Services in Canada, Department of National Health and Welfare Vol. 2, Hospital Services, Appendix 2, p. 315.

TABLE 3

AGE-SPECIFIC PATIENT DAY RATES PER 1000
POPULATION BY PROVINCE FOR HOMES FOR
SPECIAL CARE AGE 65+ IN 1965*

	<u>Canada</u>	<u>Newfoundland</u>	<u>N.S.</u>	<u>P.E.I.</u>	<u>N.B.</u>	
Rates	16,034	8,001	7,483	14,858	12,793	
Rank		9	10	6	8	
	<u>Quebec</u>	<u>Ontario</u>	<u>Man.</u>	<u>Sask.</u>	<u>Alta.</u>	<u>B.C.</u>
Rates	15,661	16,034	17,332	14,052	23,023	18,626
Rank	5	4	3	7	1	2

Klein⁽¹⁰⁾ indicates that when a population is persuaded that it can manage with a relatively limited number of acute care beds it will do so. Although strong local sentiment may put pressure on planners to keep small old-fashioned hospitals open, it may be possible to convince a community that there are other better forms of care. He cites one district in England which, being convinced of this, was able to make the reduction of acute care beds to less than 2 per 1000 before a set target date.

England, having many old hospitals and many more support services in the community and having successfully set out to change attitudes towards community care, may be able to do this, but Canadian hospitals are regarded very possessively at the present time both by patients and doctors.

FUNCTIONS OF CANADIAN HOSPITALS DEFINED BY COST-SHARING REGULATIONS

For the purposes of cost-sharing, the eligible services of Canadian hospitals and institutions have had to be clearly defined.

The following were the definitions of Levels of Care reached in Saskatchewan in 1969.⁽¹¹⁾ (The line between health and welfare responsibilities is drawn between levels IV and III)

Welfare or Nursing Care (Eligible for cost-sharing under the Canada Assistance Plan only)

Level I Care

Essentially independent but may need some guidance or supervision in the activities of daily living. Staff time for care averages 20 minutes a day.

Level II Care

Supervision and assistance may be needed with personal hygiene and grooming. Safely ambulant with or without mechanical aids or independent at wheelchair level. Usually continent. Able to feed self. Some supervision and direction may be needed for behavioural problems. Staff time for care averages 45 minutes a day.

Level III Care

All degrees of supervision and assistance may be needed in the activities of daily living. Basic nursing care is usually required. Supervision and direction may be given for emotional or behavioural problems which do not endanger life or property. Care at this level is carried out under

the supervision of a registered nurse or registered psychiatric nurse as directed by the attending physician. Staff time for care averages two hours a day.

Medical Care (General or Specialized Hospital)

(Eligible for cost-sharing under the Hospital Insurance and Diagnostic Services Act.)

Level IV Care

All patient care is carried out under continuing medical supervision and all nursing care is carried out under professional supervision. Emergency and consultative medical services and highly skilled technical nursing services must be readily available when required. Staff time for care averages more than two hours a day. There are three classifications of care at this level which are as follows:

- (a) Specialized Supervisory Care -- where the emphasis lies on the management of advanced mental deterioration with its attendant problems. Physical conditions requiring continuing medical supervision are likely to co-exist.
- (b) Supportive Care -- where the emphasis lies on skilled nursing care and specialized techniques to arrest or retard deterioration.
- (c) Restorative Care -- where the emphasis lies on a slow paced restorative program designed to improve functional ability to the extent that care at home or at Levels I and III may be achieved.

Level V Care

Intended for persons with physical disabilities who require aggressive rehabilitation by a team of rehabilitation personnel to restore or improve function. Maximum benefit is likely to be obtained within three months, after which interval the patient is appropriately transferred to another level of care. Level V treatment is provided only at the base hospitals and designated activation units.

Level VI Care

Intended for persons requiring 24 hour medical/nursing supervision for emergency, diagnostic, obstetric, psychiatric, or surgical services. Following the acute stage, the patient should, where appropriate, be transferred to a lower level of care.

The federal-provincial cost-sharing formulae have encouraged the provinces to designate large numbers of hospital beds as acute care beds (Level VI).

PRIMARY, SECONDARY AND TERTIARY CARE

In a paper written for the Project, Babson and his colleagues at the School of Health Administration in Ottawa (12) view the delivery system as one which should provide "progressive patient care". "The elements which are normally considered to constitute progressive patient care include: intensive care, internal care, self care, long-term care and home care. Of these five elements, the first four are normally associated with "horizontal patients" in institutions. As home care represents but one type of extra institutional health service, a minimum requisite for making this list comprehensive would be the addition of ambulatory care.

The fact that Babson's paper starts in this way reveals a good deal about the thinking of hospital administrators, for depending upon the availability of hospital beds, it seems to be generally agreed that 85 to 95% of care is ambulatory.

Thompson (13) has discussed the behaviour of managers or organizations, including hospital administrators who live in a climate of uncertainty. In order to cope with as much of the uncertainty as they can, they will attempt to enlarge their domains, to control the inputs into the organizations and its outputs. This will protect the technical core and enable it to perform optimally.

The argument being presented here is that the hospitals are perceived to be at the technical centre of the system of medical practice and they will exert a strong influence, through their administrators, upon this practice provided they are permitted or encouraged to do so.

It became clear in the discussion with hospital administrators that their budgets are precariously balanced.⁽⁶⁾ The introduction of community health centres will not be welcomed unless a new balance can be achieved either by giving the hospitals alternative work in lieu of the surgery and medicine removed from the in-patient care wards, or by raising the per diem rates to compensate for the fact that more complex cases will have to be carried. Presently the incentives are not in favour of emptying beds of the less ill people as far as the administrators are concerned.⁽¹⁴⁾

Slow progress has been made towards a more effectively organized system of referral. The theory of primary, secondary and tertiary care centres is there, but the system is not yet streamlined. Not only do the hospital administrators resist change in their present patterns of work, the physicians do also.

Many doctors fear making referrals to others who are not trusted personal friends or are not in partnership with them. Multi-specialty group practices in secondary referral centres that have a general practice and specialty component have to be very careful to convince doctors in outlying areas that their general practitioners are anxious not to take over their patients. A country doctor may feel safer in referring his patient to a far distant university town. In consequence a specialist in a secondary referral centre may see himself to be directly in competition with university staff. Thus the concept of primary (community-based, office and hospital), secondary (specialist care in a district hospital) and tertiary care (highly specialized care in a university hospital) is not altogether viable with the present fee-for-service rivalries.

Because of the confusions about educational costs and service costs in the medical schools the academic physicians often have had to enter into competition with the rest of the profession instead of being able to act as consultants to them, as in other countries with a national health service. In a very few cases consultancy roles have been developed by adequately salaried university teachers⁽¹⁵⁾ but the role is so strange that it has to be carried out with great tact. It is not only physicians but also hospital administrators who are resistant to consultancy on the development of their hospitals.

HOSPITAL PRIVILEGES AND HOSPITAL MANAGEMENT

In this transitional period while ideas about developing three tiers of service are getting sorted out, general practitioners have continued to seek hospital privileges. In general there is no difficulty getting into a community hospital (primary care) but secondary and tertiary referral centres are now putting up barriers of waiting periods, or probationary periods, or they are limiting the numbers of doctors they will consider enrolling. But the problem is that secondary and tertiary referral centres are often doing work at two or three levels. Thus whilst the hospitals in the big city centres have some beds for primary care reserved to general practitioners, most beds are for secondary referral and a few beds may be kept for the research and demonstration of very difficult cases. The situation is confused because these hospitals are very often used for teaching medical students who need to see all kinds of cases, but gradually general practitioner beds are being taken over by specialists.

Hospitals have power to grant or deny physicians hospital privileges and to grant or deny patients admission to beds or even day surgery. Both these powers seem to be being used differentially and to some extent capriciously. Neither general practitioners (who are given restricted privileges) nor patients (who may have to wait for what they regard as real emergencies or urgencies) are satisfied with the present organization of urban hospitals.

It is the British experience that hospital administrators have been able to get control over peripherally important technical activities only. Since the takeover of hospitals by the government, considerable progress has been made with streamlining laundry services, bulk buying of food, drugs and dressings and so on, (Palin⁽¹⁶⁾ has described a similar but slower process of centralization in Canada), but the streamlining of medical and surgical services has been very much less effective. The real power in hospitals lies with the surgeons and (less so) with the internists, for they decide on intake, length of stay, discharge and allocation of beds.

The British National Health Service alarmed at its inability to streamline the real technical core of the hospital, the medical and surgical services, has tried to interest the consultants who use the hospitals in management problems, but the Cogwheel Report of 1967/68 ⁽¹⁷⁾ has not geared up interest as was hoped. Forsyth et al. ⁽¹⁸⁾ have described the very slow progress made in this direction. It would appear that physicians and surgeons are not much interested in improved hospital efficiency. In the U.S. and Canada, accreditation procedures have developed a higher level of interest in quality control but not in cost control.

The legitimacy of hospitals as the centre of the health care system is now being challenged by the adherents of a community medicine philosophy. Equally the status and expertise of the specialist is being challenged. Is there too much surgery? It would appear that there is and that other methods of treatment could be used.

Hospitals are extensions of physicians' offices. They have provided them with facilities to do their work. If physicians are to be expected to provide more services out in the community the subsidy which has been provided by the hospitals in the past should be recognized and a transfer of costs arranged. ⁽¹⁹⁾

SUMMARY

The hospitals are symbols of community care. They cannot easily be closed. Attempts have been made to improve co-ordination of hospitals but hospitals have resisted any controls which would lead to loss of autonomy. The amount of independence they have is vague and hard to identify.

The functions of hospitals have nowhere been well-defined. Much depends upon the local community's needs and the local community's resources. Demand for hospital care and supply of hospital beds varies from place to place in Canada particularly between metropolitan and rural areas. Canada has many small rural hospitals which are uneconomic and of low technical standards but Canadians have obviously considered it to be better to have easy access to local hospitals rather than to have an economic or high quality hospital service. These attitudes are not changing quickly.

It is easier to get access to Canadian hospitals than to hospitals in some other countries which ration admission through the system of enrolment of patients in one doctor's practice. Free choice of doctor enables patients to put more pressure on physicians for hospital treatment. There are as well too many acute care beds in Canada. This results in unnecessary surgery. The incentives to hospitals encourage them to keep beds full of short-term patients. Hospitals repeat diagnostic work done out in the community for legal reasons.

There are differences in hospital use by province. Statistics show that older people in the western provinces are more frequently hospitalized than older people in the east.

Where a population is properly persuaded that it can manage with fewer beds it will do so, but Canada seems to be unready for this yet because it has inadequate community support services and hospitals are regarded very possessively both by patients and doctors.

In Canada, hospitals' functions are defined by cost-sharing formulae which distinguish between institutions giving medical and nursing or social support services. Payment is made for all patients of hospitals but only for welfare patients in nursing care institutions or homes (under the Canada Assistance Plan).

Should hospitals be regarded as the centre of the medical care system? Hospital administrators tend to think they should be. Particularly since they live in a climate of uncertainty they would like to enlarge the domains of their hospitals, to control inputs and outputs, to balance their budgets. They are unlikely to welcome community health centres which will take away some of their work and will disturb the precarious balance that has now been reached in negotiation with provincial governments.

Slow progress has been made in developing an effectively organized system of referrals. Many primary care physicians fear losing patients if they refer to secondary referral centres to which patients may decide to transfer their loyalties, so they keep work themselves or refer to tertiary centres unnecessarily. Another problem in the referral systems are the activities of academics who should be doing more consultancy but are presently competing for fee-for-service dollars. The consultancy role is not well developed because of the confusions about educational and service costs.

Meanwhile there is confusion about physicians' hospital privileges because hospitals in metropolitan centres have begun to limit admission privileges. Some physicians feel that the power to award privileges is being used capriciously and some patients feel that requests for admission to hospital are dealt with equally unsatisfactorily.

Hospital administrators cannot do much to improve these matters. The real power lies with physicians but they are not much interested in efficient management. In Canada there has been more concern about quality control than about cost control.

The legitimacy of hospitals being at the centre of the health care system is now being challenged by adherents of a community medicine philosophy. But hospitals have been extensions of physicians' offices in the past. The subsidy which this has provided to physicians should be recognized and discussed.

REFERENCES

1. Roth, F.B.: The Relationship of Hospitals to Community Health Facilities.
2. Anderson, D.O.: Personal communication.
3. Logan, R.F.L. et al: Resources and Systems in International Comparisons of Medical Care VI: The Milbank Memorial Fund, Quarterly, Vol. I, No. 3, Part 2, July, 1972, p.45-56.
4. Klein, R.: Resources, Priorities and Planning in the National Health Service.
5. Glaser, William A.: Social Settings and Medical Organization: A Cross-National Study of the Hospital, Atherton Press, New York, 1971.
6. Rosenfeld, G.B.: Summary: Seminar, Relationship of Hospitals to Community Health Centres.
7. Anderson, D.O., and Crichton, A.: Economies of Group Practice in Saskatchewan. Unpublished manuscript, University of B.C., 1972.

- Anderson, D.O.: What Price Group Practice? Crichton, A.: The Organization of Group Practice in Saskatchewan.
8. Armstrong, R.A.: Some Observations on Methods of Physician Remuneration in Canada.
 9. Greenhill, Stanley: The Distribution of Available Health Care Personnel and Health Resources in Canada.
 10. Klein, Rudolf: Notes Towards a Theory of Patient Involvement.
 11. Provincial Government of Saskatchewan: Definition of Levels of Care, 1969.
 12. Babson, J.H., Sutherland, R.W., Martin, D.L., Nightingale, D.V.: The Community Health Centre.
 13. Thompson, James D.: Organizations in Action, McGraw Hill, Toronto, 1967.
 - 14a. Foulkes, R.G.: Hospitals and Community Health Centres. Paper submitted to the Project by the author.
 - 14b. Finlay, Alan: Charts presented to the Hospital Seminar: The Relationship of Hospitals to Community Health Facilities.
 15. Crichton, A. and Price, J.D.E.: Co-ordination of Dialysis Programs in British Columbia. Canadian Journal of Public Health, Vol. 63, No. 1, Jan.-Feb. 1972, p. 45-52.
 16. Palin, Kerle: Centralization of Services.
 17. Great Britain: Ministry of Health: Organization of Medical Work in Hospitals. 1st Report of the Joint Working Party, H.M.S.O. Cogwheel Report, 1967.
 18. Forsyth, Gordon et al: In Low Gear? (An Examination of 'Cogwheels') for Nuffield Provincial Hospitals Trust by Oxford University Press, 1971.
 - 19a. Evans, Robert G.: The Impact of Health Centres on Patterns of Hospital Expenditure.

19b. Evans, R.G.: Community Health Centres and the Cost of Acute Hospitalization in Canada.

19c. Evans, R.G.: Medical Productivity and Group Practice.

THE EXISTING SYSTEM: B. THE MEDICAL PROFESSION AND ITS ORGANIZATION

FREE CHOICE OF PRACTICE

The market for physicians is a world market. They have been able to move from one country to another with few difficulties. In some Canadian provinces, the College of Physicians and Surgeons accepts the qualifications gained in other countries while other Colleges expect immigrants into the province to sit local board examinations. Much depends upon the ability of that particular province to attract and hold its doctors.

The physicians who settle in a province are remunerated mainly by fee-for-service from the medical care insurance authority if they are in clinical practice. The Canadian Medical Association⁽¹⁾ has estimated that about one-quarter to one-third of physicians are salaried but the salaried sector is made up of physicians paid from four main sources -- salaried assistants to solo or group practitioners paid from Medicare funds; academics, full-time and part-time -- the former paid entirely by the education departments of the provinces, the latter jointly by education and Medicare; physicians employed by the municipal and provincial public and mental health branches or as senior administrators in other branches; and federal government employees.

Crichton⁽²⁾ found that, in Saskatchewan, most physicians earned income (other than salaries) came from Medicare funds, whether by direct or indirect billing. The other main source of income was the contract for service which some physicians or groups had worked out with employers of large labour forces; and federal or provincial governments who had to care for institutionalized groups, in penitentiaries, for example; D.V.A. services and others. Approximately 3% of income came from the Workmens' Compensation Board, and 0.2% from the Cancer Commission. One large multi-specialist clinic had a number of private patients but in general, physicians expected to earn well over 90% of their money incomes from Medicare.

Physicians may decide to practice privately if they so wish, or to charge more than the official fee schedule rate, but it would appear that only a relatively small proportion of work is done

outside the Medicare system. In Quebec at the time of the specialists' strike it was agreed that 3% should be permitted to opt out.(3) The percentage of private work may be less in some other provinces.

Apart from relatively minor payments to laboratories*, optometrists, physiotherapists, or others, such as chiropractors the Medical Care Insurance authorities pay only for services performed by physicians, or directly supervised by physicians on payment schedules based upon the medical profession's fee schedules.

Thus in order to understand the response to financial incentives in "a subsidized entrepreneurial system" it is important to understand the development of Medicare.

Describing the historical development of the fee-for-service system, Armstrong(4), has argued that Canada's system of financing medical care is unique:

"The Canadian approach was to expand hospital on an integrated basis (catering to the rich and poor in the same institution)... Thus there were rather few private profit-making hospitals in Canada, most being built with general public support and serving their community on a more-or-less non-profit basis. Since patients were cared for in the same institutions and since it was customary for hospital privileges to be granted to physicians only on the understanding that they would carry their share of the indigent case load if need be, and since Canadians - both patients and doctors - were remarkably mobile throughout much of Canada's history, the panel practice approach...never really was accepted as a normal or generally desirable system of delivery of care, although many variants on what was basically the panel practice approach existed and still exists...It was not customary for doctors to maintain a front-door and back-door type of practice...The result of all this was that the goal in Canadian insurance programs (apart from commercial interests which were concerned with profitability and therefore very selective) was to ultimately extend similar basic coverage to all Canadians to eliminate any inequality in financial access to (medical) care between them and to enable them to consult whichever

* The "minor payments" to laboratories have been increasing and are under scrutiny by provincial governments.

doctor or be cared for in whichever hospital they chose. Of course, it took many years to achieve this. Before Medicare schemes were introduced, the provincial medical associations developed "service plans". Doctors were expected to accept the rules of the plan for all of their patients or to opt out altogether. (With certain specified exceptions the doctor had to accept the plan's payment as payment in full or operate entirely outside the plan and take his chances on collection from each patient who would receive reimbursement from the plan). Wherever these plans were available, and only Quebec had no coverage of this kind, the great majority of physicians found it to their economic advantage to participate.

Armstrong has provided a table showing the distribution of physicians by province and changes in their distribution between 1969 and 1972. (Table 4).

"It is not only by province that there are disparities in distribution", says Greenhill.⁽⁵⁾ "Doctors obviously do not wish to locate in communities remote from urban centres. Additional financial incentives such as basic salaries and fee-for-service and free housing have attracted some physicians to Canada's under-doctored localities but not as many as might have been hoped."

But he goes on to point out: "Some of Canada's larger cities with seemingly satisfactory health personnel/population ratios have no better health services in terms of accessibility and availability than some rural areas. There is no clear cut evidence to suggest a direct relationship exists between the number and types of health personnel and facilities and the health of a population...

The province of Alberta has more doctors per capita than its neighbouring province of Saskatchewan - but there are no significant differences in the health status in the population of these two provinces."

It is only 10 years since the first Medicare scheme was introduced into Saskatchewan and less than two years since the last provincial scheme was started in Quebec. Location of physicians and their patterns of practice (in terms of grouping) seem to have been developed as much in response to technological developments in medicine, as to other causes. Physicians have settled in places where they think they can make a living. Single

TABLE 4

ACTIVE CIVILIAN PHYSICIANS
(1) PER 1,000 POPULATION GENERAL PRACTITIONERS AND SPECIALISTS, CANADA,
BY PROVINCE, JANUARY 1969 TO JANUARY 1972

Province	General Practitioners				Specialists				All Physicians			
	1969	1970	1971	1972 (2)	1969	1970	1971	1972 (2)	1969	1970	1971	1972 (2)
Nfld. - Rate	.441	.510	.507	.526	.203	.252	.255	.275	.644	.762	.762	.801
% Change	15.6	-1.0	3.7		24.1	1.2	7.8		18.3	-	5.1	
P.E.I. - Rate	.555	.555	.536	.505	.273	.300	.327	.351	.828	.855	.863	.856
% Change	-	3.5	6.1		9.9	9.0	7.3		3.3	0.9	-0.8	
N.S. - Rate	.532	.553	.566	.596	.502	.515	.559	.570	1.034	1.068	1.125	1.166
% Change	3.9	2.4	5.3		2.6	8.5	2.0		3.3	5.3	3.6	
N.B. - Rate	.415	.424	.406	.450	.377	.395	.404	.405	.792	.819	.810	.855
% Change	2.2	-4.7	10.8		4.8	2.3	0.2		3.4	-1.2	5.6	
Que. - Rate	.428	.447	.455	.450	.588	.621	.660	.703	1.016	1.068	1.115	1.155
% Change	4.4	1.8	-1.1		5.6	6.3	6.5		5.1	4.4	3.4	
Ont. - Rate	.610	.643	.638	.630	.545	.567	.603	.630	1.155	1.210	1.241	1.260
% Change	5.4	-0.8	-1.3		4.0	6.3	4.5		4.8	2.6	1.5	
Man. - Rate	.544	.547	.571	.598	.532	.550	.577	.614	1.076	1.097	1.148	1.212
% Change	0.6	4.4	4.7		3.4	4.9	6.4		2.0	4.6	5.6	
Sask. - Rate	.621	.646	.663	.615	.357	.363	.401	.389	.978	1.009	1.064	1.004
% Change	4.0	2.6	-7.8		1.7	10.5	-3.1		3.2	5.5	-6.0	
Alta. - Rate	.584	.605	.611	.604	.485	.516	.544	.585	1.069	1.121	1.155	1.189
% Change	3.6	1.0	-1.2		6.4	5.4	7.5		4.9	3.0	2.9	
B.C. - Rate	.686	.720	.730	.725	.625	.639	.676	.711	1.311	1.359	1.406	1.436
% Change	5.0	1.4	-0.7		2.2	5.8	5.2		3.7	3.5	2.1	
Y.T. - Rate	.733	.813	.882	.824	.200	.188	.294	.176	.933	1.001	1.176	1.000
% Change	10.9	8.5	-7.0		-6.4	56.4	-67.0		7.3	17.5	-17.6	
N.W.T. - Rate	.452	.485	.514	.528	.032	.061	.086	.139	.484	.546	.600	.667
% Change	7.3	6.0	2.7		90.6	41.0	61.6		12.8	9.9	11.2	
Canada - Rate	.548	.575	.579	.576	.534	.559	.594	.624	1.082	1.134	1.173	1.200
% Change	4.9	0.7	-0.5		4.7	6.3	5.1		4.8	3.4	2.3	

(1) Excludes Interns and Residents

(2) Data for 1972 are preliminary.

Source: ARMSTRONG, R.A.: Some Observations on Methods of Physician Remuneration in Canada.

specialty groups of more than two physicians seem to be found only in larger urban centres (100,000 population upwards); multi-specialty groups exist in cities of approximately 25,000 and above. Specialists need to have the backing of an adequate secondary referral centre hospital. In smaller municipalities, general practice groups may recruit one specialist general surgeon, but all physicians may decide to opt for general practice if they think this enables the group to have greater flexibility.

There is a variety of forms of practice. Country practitioners may be in solo practice working out of their own homes. Solo practitioners in towns may have their own isolated offices in suburban shopping centres, but many rent offices in Medical Arts Buildings. This loose form of organization enables them to share services through rental agreements - cleaning, telephone answering, even in some cases, emergency dressing rooms planned on a rota basis. The owners of the building may also rent offices to physiotherapists, pharmacists and diagnostic laboratories, thus bringing the whole range of ambulatory care activities under one roof. The Medical Arts complex facilitates the development of rota systems and on-call arrangements.

Others prefer to practice in groups as partners. Groups facilitate referrals, informal consultations, development of support staff.

Physicians have to decide whether to practice as general practitioners or specialists. Again, the provincial colleges, which are the licensing associations under the Medical Acts, have to decide on their policies about admission to specialist practice. Normally, the physicians or surgeons must have taken the appropriate examinations of the Royal College of Physicians and Surgeons of Canada, or the Quebec equivalent. Some provincial Colleges accept 'grandfathers' who have been practicing for many years and they may permit specialists with British or American specialist qualifications to practice temporarily whilst working towards Canadian exams.

However, some physicians with Canadian specialist qualifications are practicing as general practitioners. They have calculated that they can make a better living by getting more work at general practitioner rates than by restricting themselves to a single specialty. The payment regulations of Provincial Medical Care Commissions force them to make such a choice. Thus the certified pediatrician or surgeon may "specialize" within his

group practice and do the work for which he is specially qualified, but he will also take his share of geriatric cases, obstetrics, and general counselling.

It had been hoped to get some new data on the form of practice organizations in which Canadian doctors were now working - how many were in solo practice, two-men partnerships, larger groups; in primary care or specialist groups only, or in multi-specialty practices; in rural, urban or university centres; and some information about trends.

Some data were gathered by the economists⁽⁶⁾ who made detailed reports on the western provinces for the economic study, but two attempts to get information about the present position and trends in Canada generally were not successful. Tables 5, 6 and 7 analyze the situation in the provinces of Saskatchewan, Alberta and British Columbia.

Table 5 would seem to show that in Saskatchewan, at least, there is a fairly rapid development of 2 - 4 man groups, but that the number of multi-specialty groups is now stabilized. Boan⁽⁷⁾ who tried to get some up-to-date information on trends in the same province, was unable to locate much data, but found a decline in the associations of general practitioners in urban situations and an increase in rural areas. This is perhaps not surprising since urban G.P. practices are visibly in competition with multi-specialty clinics offering a much wider service, whereas, in rural areas, roads are improving and country people may be seeking out grouped doctors in the municipalities rather than solo doctors in their own villages who do not have the back-up services. It would seem, however, that Saskatchewan is atypical of the other provinces studied.

Group practices are mechanisms for redistributing time and money and they may enable individuals to make other contributions to society such as research or committee activity. They tend to break up when personalities clash or when differences arise over the redistribution of money or time.

In order to find out more about the formation and breakup of groups, New⁽⁸⁾ discussed these matters with several practices in Ontario and Quebec. Anderson and Crichton⁽²⁾ also collected information in Saskatchewan. In that province, groupings have offered not only professional but moral support to physicians with different attitudes to practice. (Rivalries have tended to be

TABLE 5

SASKATCHEWAN: NUMBER OF CLINICS BY YEAR AND SIZE 1963-1968

Size Clinic		1963	1964	1965	1966	1967	1968
Solo*	General practitioner	158	152	163	135	144	148
	Specialist	9	7	11	11	7	7
Group:	GP	40	49	54	60	68	64
	2 - 4	1	1	2	7	5	5
5 - 9	Single Spec.	11	14	13	17	18	20
	Mult. Spec.						
10 - 19	G.P.	2	2	2	3	3	1
	Single Spec.	1	1	1	1	1	1
20 -	Mult. Spec.	5	6	6	5	8	9
Community Clinics	10 - 19 Mult. Spec.	1	1	2	2	1	1
	20 - Mult. Spec.	1	1	1	2	2	2
Community Clinics		3	3	3	3	3	3

Source: Beck, R.G.: A Report on Economics in Group Practice of Medicine (Table 1), p. 4.

* Does not include all.

TABLE 6

ALBERTA DOCTOR BILLING NUMBERS TO WHICH AT LEAST \$10,000
HAS BEEN PAID DURING THE YEAR ENDING SEPTEMBER 30, 1971,
BY SIZE AND ORGANIZATION OF PRACTICE

	Edmonton Calgary	Other Urban	Rural	All Doctors
GENERAL PRACTICE				
Solo	245	34	130	409
Groups of 2 to 4 Doctors	30	8	80	118
Groups of 5 to 9 Doctors	31	16	77	124
Groups of 10 to 19 Doctors	-	-	-	-
Groups of 20 or more Doctors	9	-	-	9
TOTAL				
SINGLE SPECIALTY				
Solo	362	33	6	401
Groups of 2 to 4 Doctors	74	-	-	74
Groups of 5 to 9 Doctors	14	-	-	14
Groups of 10 to 19 Doctors	53	-	-	53
Groups of 20 or more Doctors				
TOTAL				
GENERAL PRACTICE-SPECIALIST MIX				
Groups of 2 to 4 Doctors	4 ²	-	14	18
Groups of 5 to 9 Doctors	42	17	46	105
Groups of 10 to 19 Doctors	79	99	14	192
Groups of 20 or more Doctors	104	24	-	128
TOTAL				
MULTI-SPECIALIST MIX				
Groups of 2 to 4 Doctors	2 ²	-	-	2
Groups of 5 to 9 Doctors	3 ²	-	-	3
Groups of 10 to 19 Doctors	-	-	-	-
Groups of 20 or more Doctors	23 ²	-	-	23
TOTAL				
PATHOLOGY AND RADIOLOGY LABS				
(All Sizes)	83 ³	4 ³	-	87
TOTALS	1158	235	367	1760

1. Omitted because these doctors work in emergency departments.

2. Omitted because data pertains to only one group.

3. Omitted because size and specialties are not accurately known.

Source: Haythorne, D.F.: A Study of Alberta Health Care Insurance
Commission Payments to Alberta Doctors by size and organiza-
tion of practice.

TABLE 7

NUMBERS OF GROUPS, PHYSICIANS, AND AVERAGE INCOME
IN VARIOUS SIZES AND TYPES OF GROUPS IN B.C.

	ALL GPs	GPs AND SPECIALISTS	MIXED SPECIALTY	SAME SPECIALTY	TOTAL
<u>2 - 4 DOCTORS</u>					
No. of Groups	73	16	2	3	114
No. of Physicians	171	44	6	55	276
Average Income	39,694	44,058	182,273	78,471	51,217
<u>5 - 9 DOCTORS</u>					
No. of Groups	11	13	1	5	30
No. of Physicians	68	78	6	22	174
Average Income	32,343	43,674	63,351	88,057	45,536
<u>10 - 19 DOCTORS</u>					
No. of Groups	1	10	-	1	12
No. of Physicians	8*	105	-	9*	122
Average Income	36,269	37,827	-	50,987	38,696
<u>20+</u>					
No. of Groups	-	4	-	1	5
No. of Physicians	-	84	-	31	115
Average Income	-	37,461	-	30,498	35,584
<u>TOTAL</u>					
No. of Groups	85	43	3	30	161
No. of Physicians	247	311	12	117	687
Average Income	37,559	40,076	122,812	65,449	44,937

*One or more physicians in the group were members for only part of a year and hence earned less than \$10,000.

Source: Evans, R.G.: Medical "Productivity" and Group Practice
(Table 111) p. 9.

expressed in political terms when the mode of practice also differed). The physicians practicing in the style shown at the bottom of the medical model pyramid (Chart 1, Chapter 2) have been regarded as left-wing socialists by those taking up other positions on the pyramid. Their main objective, however, seems to have been to demonstrate a new form of medical practice, judging by their concern to research and publish to an international medical care interest group rather than promote political objectives.

PRIMARY CARE SERVICES

In an attempt to find out more about primary care physicians, six papers were commissioned by the Project - two on general practice and four on specialist primary care. One paper drew attention to the definition of a primary physician prepared by the Community Health Care Committee of the Ontario Council of Health.⁽⁹⁾ This divides family physicians into three groups:

- (a) Unrestricted - a physician who contracts with patients of all ages to make medical care available to them at all times for any health problem and to accept a continuing responsibility for their medical care and improved health maintenance;
- (b) age and sex restricted, e.g. pediatricians, internists, obstetricians;
- (c) problem restricted, e.g. ophthalmologists, dermatologists.

"The role of the family physician is:

- (a) primary diagnosis for all types of health problems;
- (b) provision of medical care for those health problems which lie within his scope;
- (c) supervision and co-ordination of care for patients requiring specialist diagnosis and treatment;
- (d) maintenance and expansion of health for the patient population forming his practice;
- (e) protection of the specialist expertise of the specialist."

The Committee stress three features of family medicine
(1) the team approach (2) personal and (3) continuing care.

There is, as well, emergency care which may be impersonal and episodic.

Steele(10) draws attention to the special problem of the primary care physician, which is to combine personal concern with high technical standards. The solo practitioner appears to be more likely than the group member to show this personal concern, but tends to have lower technical standards.

Steele points out that 53% of all Canadian physicians were in primary care in 1968 (i.e. 11,495 out of 21,359 physicians); 2525 of these had certification in pediatrics or internal medicine.

GENERAL PRACTICE

Steele's paper goes on to describe general practice in Eastern Ontario. It is not known whether this is typical for other parts of Canada but it does give a picture of one area.

In 1971 there were 37 practitioners - solos and two-man partnerships - in Kingston (63,000 population). Ten shared offices with one other doctor. "There were five full-time and one part-time nurses, the rest had lay receptionists. Many practices were closed to new patients. In the surrounding countryside, 10 solo practitioners were located in villages (pop. 20,000 - 2000 square miles). Many were about to retire and replacements were not visible. Practices were not 'closed' and there was a lot of seasonal work, so doctors worked very hard. Most did only office practice with a few house calls. Hospital work was referred. Offices were ill-equipped, there were no effective appointments systems, three of the 10 had R.N.'s to assist as receptionists (two part-time). In the district as a whole the nurses did not help with patient care and there was really no room for them to work in 31 offices. "The outstanding conclusion is that the standard of management is seriously deficient (although)... new diagnostic tools and new therapies are used, but the methods of handling the patients and the working quarters of the doctors (are outdated)." Nor did the doctors seem to want to change their ways.

"Whilst most family physicians jealously guard their hospital privileges, it is not unusual to find a decline in the use of hospital facilities by those same physicians with a compensatory increase in office practice - there is, in effect, a contraction of activities to the primary care physician's office from the patient's home and the hospital."

PEDIATRICIANS

Moghadam⁽¹¹⁾ says that there were 769 active pediatricians in Canada in 1968. Of these, 70% were providing primary care. "If all pediatricians were to restrict their practice to consultation, most would not be able to survive financially."

Nevertheless, they must have made a very restricted contribution to primary care since 82.4% were located in metropolitan areas (in which 48% of the population lived) and 55% were in higher and middle socioeconomic areas and 33% in mixed areas. Thus only 12% were in lower income group areas. Despite the fact that the child population is decreasing in numbers, "there is a slow but continuing increase in the number of pediatricians trained in Canada. There is no agency or governing body which regulates the entry of physicians into pediatric (or any other specialty). No one has estimated the needs of this nation for pediatric consultants." Moghadam thinks that there is a waste in a four-year training program. Few pediatricians who practice as consultants could be labelled general consultants; most become superspecialists after more training and work at the tertiary level. For community pediatrics two years training would be long but the emphasis in the training should be quite different. There is need for child specialists to deal with problems such as those outlined in the CELDIC Report.⁽¹²⁾

INTERNISTS

Spaulding⁽¹³⁾ says of the internists: "Unfortunately the role of the internist either as a primary care physician, a consultant or a mixture has never been determined...Commonly, a highly trained young internist, having completed a residency program designed to fit him for consulting practice will establish himself in a populous area and not confine himself to referred work. By being available and accepting non-referred patients he demonstrates to the public that at least some internists, including some sub-specialists, consider primary care to be part of their professional activity. The confusion of role has to be eliminated before rational utilization and distribution of internists can occur." Data about the number of internists and their technical skills in the various sub-specialties are not available in Canada. Consequently, some rough guesses were made about the province of

Ontario by way of illustration. "Manpower production in internal medicine in Ontario, although appropriate in 1970, will be excessive in 1975. Manpower production in rehabilitation medicine, inadequate in 1970, will be appropriate in 1975...There appeared to be little, if any, overproduction in sub-specialties. By 1975, there will be a serious underproduction of oncologists, clinical pharmacologists and rheumatologists, and no sub-specialists will be qualifying in clinical epidemiology, genetics, geriatrics and infectious disease." However, this last statement is qualified by the comment that "a substantial number of general internists have had some sub-specialty training." Spaulding does not think that internists should practice as primary physicians but as specialist consultants. They could be based either in a hospital or in a group community practice where there are laboratory and radiological facilities, and primary physicians and other consultant specialists. As well as doing referred work they would then be available for information, consultation and continuing education. Because of the role confusions at the present time, training programs are not as effective as they might be.

OBSTETRICIANS

Bryans ⁽¹⁴⁾ estimates that about 60 to 70% of obstetrical care in Canada is given by general practitioners. No hard data are available. The obstetricians and gynaecologists are located in the metropolitan areas and larger towns (25,000+). Less than 25% of deliveries are made by obstetricians in these towns and less than 50% in metropolitan areas. In 1970, 984 specialists were distributed very unevenly over the provinces: Maritimes 57; Quebec 284; Ontario 406; Prairies 147; B.C. 90; Yukon and N.W.T. 0. "Obstetricians and gynaecologists do provide a significant amount of primary care...The percentage of work done by the obstetricians and gynaecologists that is primary and that which is truly consultative referred work would vary greatly, but certain generalizations are possible:

1. Only a small percentage of specialists do consultation work exclusively.
2. A higher percentage of primary care is delivered by the specialist practicing in a large metropolitan community.
3. The specialists serving a scattered large area of low density will do a higher percentage of consultation work.

4. Age has a direct relation - younger men do more primary care; older specialists are more likely to limit their practice and do more referred work.
5. Younger specialists do relatively more obstetrics; older specialists do significantly more gynaecology.
6. Recipients of primary obstetrical care by specialists would show a distinct weighting to middle and higher socioeconomic groups, whereas women referred to the specialist for consultation would be representative of all social groups.

In discussing the deficiencies and strong points of the present methods of delivering obstetrical care, Bryans points out the following weaknesses: lack of uniform standards and adequate peer review in pre- and postnatal care; probable costly duplication of overheads; waste of specialist skill in primary obstetrical and preventive gynaecological care; maldistribution of specialists and double standards of care; prenatal mortality rate improving but still unsatisfactory. The strengths are, in his opinion, voluntary controls and educational programs which have led to continually rising standards of maternal and prenatal mortality; free choice of doctor and direct access to specialist care for those who choose it and are willing to pay for it; close doctor-patient relationship which may be lost in a team situation, and close personal interest and responsibility on the part of the doctor; "it remains to be proven that less qualified personnel can do prenatal and periodic examinations as efficiently, as economically and without associated disadvantages", he says.

Not everyone would agree with this last comment. Mott⁽¹⁵⁾ suggests that a number of experiments in using nurse midwives indicate that they can give a first-class service.

Bryans suggests a breakdown of the obstetrician/gynaecologist job into four parts: (1) periodic examinations of cervix, breast and ovary for early cancer detection; (2) family planning; (3) abortion; (4) concern for good quality of reproduction - genetic counselling and emphasis on specialist care for the high risk patient. So far as family planning and abortion are concerned, Mackenzie⁽¹⁶⁾ suggests that a cheap, streamlined, widespread and effective service could be organized with a few qualified staff and many technicians.

PSYCHIATRY

Coates⁽¹⁷⁾ has discussed the ambiguous position of psychiatrists in relation to primary care. There are, he suggests, four models of disorder treatment theory which may determine their approaches.

CHART 6 - FOUR MODELS OF DISORDER TREATMENT THEORY

DISORDER THEORY	PROFESSIONAL ROLE	TYPE OF TREATMENT
(1) Medical	Doctor	Drug therapy
(2) Psychoanalytic	Psychotherapist	Psychotherapy, group and family therapy
(3) Crisis and Miasma	Social system manipulator	Crisis intervention
(4) Social Competence	Teacher	Reeducation, skill training

"The first two", he says, "are clinical models, the latter two non-clinical". Coates' paper traces historical developments in the psychiatrists' opportunities in Canada which has approximately 2,000 specialists. No hard data are available on their distribution but approximately one-half are practicing in Ontario and half of these are in metropolitan areas. Despite this, few smaller centres are short of psychiatrists and only in the very sparsely settled areas is there a true shortage in relation to population. Saskatchewan has the most equitable distribution.

"Historically, psychiatrists run counter to all other specialists in that, until 1950, the majority were either mental hospital staff or university staff, i.e. salaried, and of all the medical specialties, psychiatry is the most socialized both in this respect and in acceptance of working as members of a team... Much of the literature on health care teams derives from this orientation and much of the empirical research on professional roles has been based on psychiatric hospitals, clinics and mental health teams..."

"However, psychiatrists have had to struggle for status within the medical profession. The 1960's was an era in which psychiatry became conventional and conformist, i.e. it emerged as a full-fledged medical specialty in terms of patterns of practice on a fee-for-service basis. Moreover, the same decade

saw the acceptance of psychotherapy as a medical procedure with professional safeguards against non-physician practice. The development of psychotherapy as an exclusively medical procedure has given rise to some extreme statements regarding the role of the psychiatrist, but also runs counter to the common-sense view that a variety of other professions, specifically clinical psychologists, social case workers, clergy, physicians to a limited extent and counsellors in school systems and regulatory agencies share an overlapping function, without either professional sanctions or the provision of coverage in prepaid medical schemes."

Coates points out that most psychiatrists like the medical specialist role because it pays well and also it "consolidated the professional role lacking in the prior practice arrangement of mental hospital or mental health clinic. It has also made for an arrogance regarding the professional privileges to define patients in need of treatment, types of treatment and duration, and also provide disincentives for consulting and educative functions which are not part of the pre-payment contracts."

"The community psychiatry orientation has been largely a counterforce to established clinical activities carried on in part by psychiatrists ideologically dissatisfied with the private practice model and, in part, through specious arrangements, under which agency and community counselling were carried on under the guise of treatment for individual patients. Government (has continued) to control a third stream identified with community psychiatry, the community mental health clinics which are prominent in Nova Scotia, New Brunswick, Saskatchewan and British Columbia despite the remuneration being consistently about \$10,000 per annum below comparable practice earnings." He points out that an obvious double standard in the private and salaried system exists.

Training for psychiatry in Canada is "heavily weighted towards psychodynamics and psychotherapy and turning out a specialist oriented towards private office practice and general hospital psychiatry. Consulting is a matter of low prestige and no university department to date has developed either a course or a formal training program in consultation, in agency work, or in a community orientation".

The most detailed picture of Canadian practice is provided by Hanley⁽¹⁸⁾ who surveyed Ontario psychiatrists in 1970 and concluded:

1. "An extensive shortage of psychiatrists exists.
2. Psychiatrists, by defining the essential function of diagnosis and therapy as 'medical acts' have curtailed the involvement of 'senior mental health' staff (clinical psychologists and social workers) in treatment.
3. Yet psychotherapists do not perform any physical diagnosis, nor do they recognize their specialist medical training as a necessary prerequisite for psychotherapy practice.
4. Though general physicians treat at least 85% of all psycho-neurotic conditions in their practice, psychiatrists feel that the quality of the treatment is uncertain because of limited professional time and lack of psychodynamic training.
5. There is a new and unique professional role of psychotherapist which could be undertaken by those with basic training in medicine, psychiatry or social work. Non-medical therapists need to retain the legal safeguard and to work only with medically referred patients."

Coates is doubtful about the future of community psychiatry. Because psychiatrists are so insecure within the medical profession "the likelihood of reversing the trend and making psychiatrists both more accessible and relevant to general health and social services is unlikely to be successful. The general trend towards a private practice referral system, particularly in the large urban centres has accentuated the demand for service, whereas the preventive pattern of a separate treatment system (largely in provincial government hands) of mental hospitals and mental health clinics created a severe constraint on availability. Nowhere has equilibrium been reached in these two provisional models and no attempt has been made to explore a system of disincentives to hospitalization or specialized treatment."

THE PRIMARY CARE SPECIALISTS

The evidence from all sources about specialists who have a stake in primary care is similar:

- (i) The field is divided between general practitioners and specialists. General practitioners deal with most of the patients in rural areas, for specialists

are located in the towns; there is a visible double standard because of the inequitable distribution of services;

- (ii) the specialists are obliged to compete with the general practitioners for primary care dollars because they could not live on referred work only, but the specialists are not trained for community service but for highly specialized consultancy work;
- (iii) there are too many specialists in most of the specialties and sub-specialties for the consultancy or hospital work now available, and there is no manpower planning to help intending consultants to choose to train for specialties which are undermanned.
- (iv) because the specialists are so uncertain of their roles they are retreating more and more into attitudes of medical professional dominance. Team-work or delegation to pediatric nurse practitioners or midwives in rural areas was hardly mentioned, and the discussions focussed as much upon medical professional rivalries as co-operation with other health professionals in community health centres despite the fact that these were specially commissioned papers;
- (v) the high status activities seem to be associated with tertiary clinical consultations (referrals) or primary care consultations with upper-class patients rather than community consultancy activities. This may be due to payment arrangements or may, as Coates says, mean that agency or community consultancy is not regarded as carrying any prestige.

SUGGESTED REMEDIES

1. One remedy that has sometimes been proposed to overcome these deficiencies is group practice. (In Britain, which had a similar pattern in the mid-sixties, incentives were given to physicians who moved into offices together and engaged secretarial help. This resulted in most doctors grouping.*)

Davidson (19) describes how well-managed group practices can legally manipulate the tax system to their advantage. Some physicians are much better at exploiting the system than others whose management is of "the cottage industry" type.

Anderson and Crichton found that, among other things, groups could improve leisure through rota systems, could redistribute income in what they perceived to be a more equitable manner, could facilitate educational and research pursuits and probably give a better quality of service (at least a different service) because of interprofessional interaction and informal consultation.

But as Evans (20) points out, "grouping by itself will not necessarily improve physician productivity. Canada-wide it would be approximately equivalent to a one year 'physician-stock' increase. More radical changes in medical practice might increase productivity but the impact of such changes cannot be estimated now. Much would depend upon the particular incentives used to motivate the physicians."

2. Nurses and other health professionals are angry at the assumptions about all knowledge and power resting only in the medical profession and about what they see being done by doctors. They believe they could raise standards of care if community health centres were developed, for grouping of practices perpetuates the dominance of the physicians and does not open the service up to teamwork developments.

* A group in Britain is not necessarily a legal partnership but may be only a sharing of premises, secretarial and other support services. It may be an arrangement of the same nature as the Medical Arts Building arrangements in Canada. In Canada a group has been taken to mean a partnership of three or more physicians.

Neither group practice nor attempts at developing teamwork are likely to be successful unless the total health care system is changed.

PHYSICIANS AND HOSPITALS

The survey of the existing system began in the previous chapter with the hospitals, not only because they are the most expensive part of the Canadian health service, but also because they have provided one form of linkage between the individual physician entrepreneurs. Hospitals have been very important centres for the doctors. They have enabled physicians to meet regularly, frequently, locally and informally if they have hospital privileges and if they so wish. "Hospital privileges" is an emotive concept for physicians in Canada. A large group of immigrant physicians feel strongly about the exclusion of general practitioners from British hospitals. The lack of hospital privileges for British general practitioners led to their isolation, their failure to keep up to date with developments in medical care, and considerable dissatisfaction sometimes leading to emigration to Canada or Australia. They also want to be allowed to do minor surgery and specialty general practitioner work and they feel the need of hospital support to do this.

Without having direct access to hospital beds, operating rooms, delivery rooms etc. and/or a satisfactory access to the referral system, Canadian practitioners are severely restricted. In the past good contacts with the referral system depended upon the informal relations developed in hospitals or through attending association meetings.

As well, Canadian patients have put great emphasis on the right to be treated in hospital when they are ill.

SUMMARY

The market for physicians is a world market. The Colleges of Physicians and Surgeons in the Canadian provinces recognize this in their licensing arrangements. Some can afford to be more demanding than others in setting examinations for immigrants.

About one-quarter to one-third of physicians are salaried. The rest are remunerated mainly from Medicare funds. Some have contracts of service with private employers or governments, and a few have private patients. Probably 90% or more of physicians' incomes is from Medicare.

The Medical Care Insurance authorities may also pay laboratories, optometrists, physiotherapists, chiropractors according to provincial regulations but these are minor payments compared with the amounts paid to physicians for services directly performed or supervised by them.

Historically, Canada has had a single standard of medical care. Physicians encouraged the development of insurance programs so that patients could have equitable treatment both in and out of hospitals.

There are disparities in the distribution of physicians both between provinces and within provinces. Doctors obviously do not wish to locate in communities remote from urban centres. Additional financial incentives for rural and northern areas have not attracted enough to correct disparities. However, the availability of physicians does not necessarily mean better health status for the population.

Physicians are distributed in places where they think they can make a living and they will form groups if they think this will assist them to do so. There is a variety of forms of practice and physicians have to decide what is best for them, whether to work alone or with others, and as general practitioners or specialists. Not much is known about trends in co-operative working together or partnership practice. Some tables showing patterns in Western Canada are provided.

Because physicians are remunerated as individuals, groups may form and break up quickly. Groups may offer both professional and personal support to their members.

Six papers were commissioned on primary care.

Primary care may be given by general practitioners (now usually called family physicians) or specialists. The role of the family physician is said to be primary diagnosis, treatment within his scope, supervision and co-ordination of specialist treatment, maintenance and expansion of health for members of his

practice, protection of specialists' expertise. Family medicine is concerned with personal continuing care and the team approach. Personal care is likely to be better if given by solo practitioners, technical care better if given by group practitioners. In 1968, 53% of Canadian physicians were in primary care and 11.5% of these had specialist qualifications in pediatrics or internal medicine.

In rural Ontario, physicians are poorly organized and do not use much help. Group practice has been developing in some provinces but insufficient information has been collected to indicate trends. In any case groups may not improve the use of scarce resources without other forms of organization of work.

Reports on the work of four groups of specialists - pediatricians, internists, obstetricians and psychiatrists - indicate that these specialists are not distributed in the districts where the need for them is greatest, nor are they able to act as consultants when this might be more useful than practicing as clinicians. In mental health, the work is divided between the psychiatrists financed from Medicare sources and those on Provincial Mental Health Department payrolls. The trend is away from community psychiatry towards individual psychotherapy. The evidence about all four groups of specialists is similar:

- (a) there is uneven distribution of specialists who are usually located in large urban centres,
- (b) the specialists who are trained for tertiary care find that they have to compete with primary care physicians for dollars,
- (c) there are too many specialists in many specialties and no manpower advisory service to help them to make good choices,
- (d) the specialists are not geared to teamwork with other health professionals,
- (e) high status is not associated with community orientations but with tertiary care.

Suggested remedies for these deficiencies have been (a) group practice, (b) teamwork. But neither is likely to be effective unless the total health care system is changed.

Physicians have a high regard for hospital privileges. There are several reasons for this:

- (a) it is an emotive concept for British immigrants,
- (b) it enables them to treat patients with proper support,
- (c) this support is a hidden subsidy to them,
- (d) hospitals are the centre of the medical professions' communications and social network and it is in hospitals that the professional controls use of beds, admission, waiting lists, etc.

Any attempt to exclude community clinic physicians from hospitals is very important symbolically, for hospitals are at the heart of the medical profession's activities. The priorities given to the use of hospitals by the profession is now causing some disquiet to the public and to provincial governments.

REFERENCES

1. Ruderman, P.: Summary,
Seminar on Financial Matters.
2. Anderson, D.O., and Crichton, A.: Economies of Group Practice
in Saskatchewan. Anderson, D.O.: What Price Group Practice?
Crichton, A.: The Organization of Group Practice. Unpub-
lished manuscripts. University of British Columbia, 1971.
3. Taylor, Malcolm G.: Quebec Medicare: Policy Formulation in
Conflict and Crises, Faculty of Administrative Studies,
York University: unpublished manuscript, 1972.
4. Armstrong, R.A.: Some Observations on Methods of Physician
Remuneration in Canada.
5. Greenhill, Stanley: The Distribution of Available Health
Care Personnel and Health Resources in Canada.
6. Beck, R.G.: A Report on Economics in Group Practice of
Medicine.
Evans, R.G.: Medical "Productivity" and Group Practice.
Haythorne, D.F.: A Study of Alberta Health Care Insurance
Commission Payments to Alberta Doctors by Size and
Organization of Practice.
7. Boan, J.A.: personal communication.
8. New, P.: personal communication.
9. Ontario Council of Health: Report: Supplement No. 5: Health
Delivery Systems, Community Health Care: Queen's Printer:
Toronto 1970.
10. Steele, R.: Current Patterns of Primary Health Care Delivery.
11. Moghadam, H.: The health care of children in the 1970s and
beyond.
12. The Commission on Emotional and Learning
Disorders in Children: One Million Children. L. Crainford
Toronto, June 1970.

13. Spaulding, W.B.: The Future Role of the Internist.
14. Bryans, F.E.: The Role of the Obstetrician.
15. Mott, Frederick, D.: Personal communication.
16. Mackenzie, C.J G.: Birth Control in Canada.
17. Coates, D.: Mental Health Aspects of Primary Health Care.
18. Hanley, C.: "Psychiatry", Mental Health in Ontario, Queen's Printer, Toronto, 1970.
19. Davidson, W.T.T.: Accountancy and related aspects of Group Practice.
20. Evans, R.G.: Medical Productivity and Group Practice.

THE EXISTING SYSTEM: C: RESISTANCE TO CHANGE BY PHYSICIANS

PAYMENT SYSTEMS AND PROFESSIONAL AUTONOMY

There are two main bastions around which physicians' resistance to change is organized - Payment systems and professional discretion.

Two commentators from Britain, Logan⁽¹⁾ and Pole⁽²⁾ have drawn attention to the question of 'felt-fair' incomes for physicians. Pole points out that it is important to recognize that physicians expect not only to have direct incomes to cover office overheads and take home pay, but also subsidies. These may take the form of access to hospital facilities and support services or, alternatively, if community care is to be made attractive, some other emoluments, such as secondment of public health nurses to their practices (as in the British health centre model). The struggle for hospital privileges is not only a struggle for access to one of the principal communication and status networks of physicians but also for hidden subsidies ⁽³⁾, which are taken as a right by specialists.

The so-called doctors' strike⁽⁴⁾ in Saskatchewan in 1962 led to a struggle within the medical profession about the granting or withholding of hospital privileges to the community clinic physicians who wished to develop new forms of practicing. This was the method by which the established profession could hit back at the innovators who were bringing in changes which they feared. The principal threat was 'consumer involvement'.

The Woods Commission 1963⁽⁵⁾, which investigated the withholding of privileges to some of the immigrant physicians practicing in community clinics made it clear that this was the principal issue in the quarrel between the physicians. It was thought that the community clinic physicians were being "told what to do" by their Boards, although these physicians themselves were most anxious to limit the relationship to that spelled out in the Saskatoon Agreement 1962, which had ended the 'strike'. One of the clinics, particularly, had real problems with its Health Services Association Board which had a large number of professional members⁽⁶⁾. These were people fairly well versed in the problems of health care organization (civil servants and university professors) but they seem to have been unable to understand the limits of their roles as Board members.

What the established physicians were anxious to prevent was the access of the community clinic physicians into the heart of their social system. The importance of this 'closed' system to them has not been well explained.

Powell(7) recalled his relationship (as Minister of Health) with the British medical profession in those terms: "The unnerving discovery every Minister of Health makes at or near the outset of his term of office is that the only subject he is ever destined to discuss with the medical profession is money. Cynically, but unjustly, he may be tempted to assume that this is because money is the only thing the medical profession cares about. It is not so. What has happened, is that the nationalized service makes money the sole terminology of intercourse between professions and government."

Glaser (8) an economist who has made an analysis of payment systems in 16 countries, quoting Powell, has said "But, of course, doctors are at least as deeply concerned with the substantive content of their work: that employment should yield more than instrumental returns is one of the essential characteristics of a profession... Because of the customary professional autonomy over the substance of the job and because of its supposedly esoteric nature, doctors make little effort to communicate knowledge to the laity about the other things that interest and motivate them, and the medical administrators and the press hardly bother to learn and publicize these matters." It would seem that Glaser has really missed an important point. The concealed part of the system is deliberately concealed, it is what being in the profession is all about: having access to the referral system, access to hospital privileges and to beds, to the use of operating theatres, to support staff paid by others. Powell, anxious to improve management in the British National Health Service, had little success because all kinds of irrelevancies were used to baffle his intervention into traditional ways of doing things.

By keeping information concealed within the professional group the physicians are able to retain legitimate control over an important part of the system. They can then apply their own rationale to the organization of priorities. On the surface this is an expert rationale used by a highly respected status group, but the public is getting more and more concerned about leaving it in their hands.

Provincial Colleges and Associations find that they now have to work very closely with provincial governments. At the same time, they wish to maintain optimal control over the organization of the medical care delivery system but realize that they will have to make changes. Unfortunately, there is a tendency to wait for suggestions about change to come from the governments rather than from professional sources and even when they do come from within the profession they are often strongly resisted. The attempts to establish prepaid group practices in some parts of Ontario were met with considerable hostility, and the ostracism of the physicians who started the Saskatchewan community clinics is a matter of record.

The Provincial Colleges and Associations do not seem to have wanted to or been able to come to grips with medical manpower distribution, or radical changes in payment systems.

Little seems to have been achieved in getting medical manpower to locate in areas that need physicians. Manpower planning seems to fall between provincial government, medical professional groups, universities and immigration authorities. Ontario has made special efforts to find inducements for physicians to locate in rural areas and a special adviser⁽⁹⁾ has been appointed to help physicians to set up practices outside the cities. Financial incentives are also offered to young physicians willing to work in the north for a period.

Wilson⁽¹⁰⁾, who has had a long association with the British Columbia Medical Association, has described the attitudes of the doctors-in-association who are somewhat resistant to change in the present organization of health care delivery. They believe that they have been willing to make changes in the system of delivering care when the population has made its desires known (as in developing non-profit medical insurance programs before medicare). They believe that citizens in general are very satisfied with the present system of health care and the personal services of their doctors. They think that more government intervention is going to lead to more paperwork and more bureaucratic control over their activities.

These views were also expressed by Smith⁽¹¹⁾ in a paper written for the physicians' seminar.

Blishen⁽¹²⁾ examined the development of the ideology of Canadian physicians between 1953 and 1965. He points out that "As members of a profession, individuals perform specialized

roles in relation to clientele. In doing so they encounter certain strains; these in part are resolved both verbally and symbolically by the reiteration of basic values or themes which shape the professional ideology." But the way in which the doctors visualize their roles and the way in which patients vary their role performance may create strains when their expectations do not coincide. Blishen analyzed the frequency of statements by physicians in association during the period of his study and from these ranked their concerns in order as follows: Professional control, freedom, responsibility, voluntary availability, voluntary participation, universal availability. He concludes: "Despite the many strains and pressures facing a medical practitioner, the medical ideology provides him with enough support for him to carry out his professional responsibilities... For a physician the present content of medical education, the organization of the various forms of practice and hospital activities, the degree of control exercised by colleagues and the organized profession, and his relationship with third parties, all of which impose severe strain and create anxiety, are preferred to a different medical care system... There is a built-in resistance to change in the profession, particularly when the impetus for change comes from outside with the possibility of outside control of professional activities. The strength of the prevailing medical ideology may prove a serious obstacle to change in the organization of medical care."

Klein⁽¹³⁾ in a paper on accountability in the British National Health Service, points out that the "NHS is the only example of... 'worker's control' in any major industry, let alone a publicly financed service. Not only do the doctors control the service at the point of delivery, i.e. deciding who is given what treatment, equally they - and increasingly also the nursing and other health professionals - are represented on boards of management and advisory committees. The problems of devising a system of public accountability in the NHS are therefore compounded by professional insistence on self-accountability, and attitudes epitomized by the British Medical Journal when it wrote: "There is complete agreement within the profession that the Health Service should be run by doctors and not by laymen - either social scientists or professional civil servants."⁽¹⁴⁾ Accountability in the NHS should mean, I suggest, the acceptance of the responsibility publicly to explain and justify policies, to welcome rather than stifle discussions of priorities and objectives, and awareness and sensitivity to public needs, and finally a willingness to admit to and remedy errors. In short, the NHS should be a

open consumer-oriented organization instead of a closed syndicalist corporatation."

There is, of course, much of the same feeling in Canada.

PHYSICIANS' INCOMES

A report of the Department of National Health and Welfare, 1971⁽¹⁵⁾ gives the most recent information about earnings of privately practicing physicians: "The average gross professional earnings of fee-practicing physicians in 1969 were \$46,328, which was 8.3% higher than in 1968 and 79.1% higher than in 1961. The highest average gross earnings in 1969 were reported in Alberta, at \$52,383. In Ontario, Manitoba and Newfoundland they were above national average and in the remaining provinces, they ranged from \$45,010 in Saskatchewan to \$34,595 in the Yukon and Northwest Territories.*

Generally, through the nine-year period 1961-69, average gross earnings have been at a higher level in Newfoundland, Ontario, and the western provinces than in Quebec and the Maritime provinces.

The net returns to physicians, after deduction of the expenses of professional fee practice, reveal similar geographic patterns. Net earnings for Canada as a whole average \$30,861 in 1969, 7.9% higher than in 1968 and 87.4% above the 1961 figure. The highest provincial average net income was reported by Newfoundland physicians at \$37,817 followed by Ontario physicians at \$33,903; the lowest average net income, \$15,807, was reported in the Yukon and Northwest Territories."*

"There would appear to be no doubt that existing fee schedules influence patterns of medical practice - or at least patterns of medical billing," says Armstrong⁽¹⁶⁾.

* In contrast, according to the information published by Statistics Canada, the average individual income in Canada was \$4,710 and the average family income \$8,927 in 1969.

"The greatest criticism of the fee-for-service system seems to relate to the incidence of surgery on the one hand and hospitalization on the other, which tend to be higher in the U.S. and Canada than, say, in the U.K., and in the U.S. rather lower under the Kaiser Permanente capitation system than under F.F.S. arrangements."

Now, he believes, there is need for more fact finding in order to readjust the system to a new fair division of the money available.

Armstrong continues: "To date there has been little hard data available as to the working life of the various types of practising physicians", but a preliminary study of 1969 income tax data has provided the following information:

TABLE 8 - PHYSICIANS' INCOME - SPREAD OVER YEARS OF WORK

Type of Practice	Average Age of Reaching <u>Full</u> Earnings ' Range	Average last Age in Full Earnings ' Range	Average Period of <u>Full</u> Earning Power
General	31 years	62 years	31 years
Pediatrics	35	66	31
Internal medicine	34	60	26
General surgery	36	58	22

"... The tremendous increase in medical specialization since World War II has resulted in what is undoubtedly a situation of relative over-supply of certain specialties - at least in many metropolitan areas and probably nationally as well. Cynics (non-surgeons) have said that the incidence of surgery parallels the incidence of surgeons... Within Canada there is a wide variation among provinces in the ratio of surgeons per capita and surgical rates per 1,000 beneficiaries also vary - but the variation seems to at least equally parallel the availability of short-term beds as the availability of surgeons..."

Armstrong goes on to argue: "An urgent reassessment of the specialty requirement ratios recommended some years ago by the Royal College, of the number of approved residencies supported by public funds and of the immigration policies relating to physicians is required."**

Some attempts have been made by the Health Resources Branch of the Department of National Health and Welfare and the Royal College to explore the question of the mix of physicians in the provinces, but we have not had access to the findings. There seems to be no doubt, however, that adequate services could be provided by far fewer physicians, especially if more of them were general practitioners and better distributed.

Greenhill(17) believes that: "The total available health personnel (i.e. doctors and nurses) is more than adequate by international standards and in comparison with countries of similar economic and technological status... The status 'mix' of the health professions appears unnecessarily 'high priced' in type for Canada's present and future health needs."

Logan et al(18) produced comparative histograms of the mix of different kinds of health professionals in different countries for the international study. The first four items in Chart 7 show the position in the study areas in three western provinces of Canada. (The Saskatchewan study area included the university town, the other three were rural areas. This would account for some discrepancies.)

"It is tempting to conclude that any relation between investment in manpower and use of health services is fortuitous, (but) more work (needs to be) done (on) the appropriateness with which different manpower skills are deployed. To what extent is each skill under - or overused? In the absence of this dimension, most manpower planning is an extrapolation of existing national trends. Similarly, the important question of the relationship between investment in manpower and investment in capital equipment needs consideration."

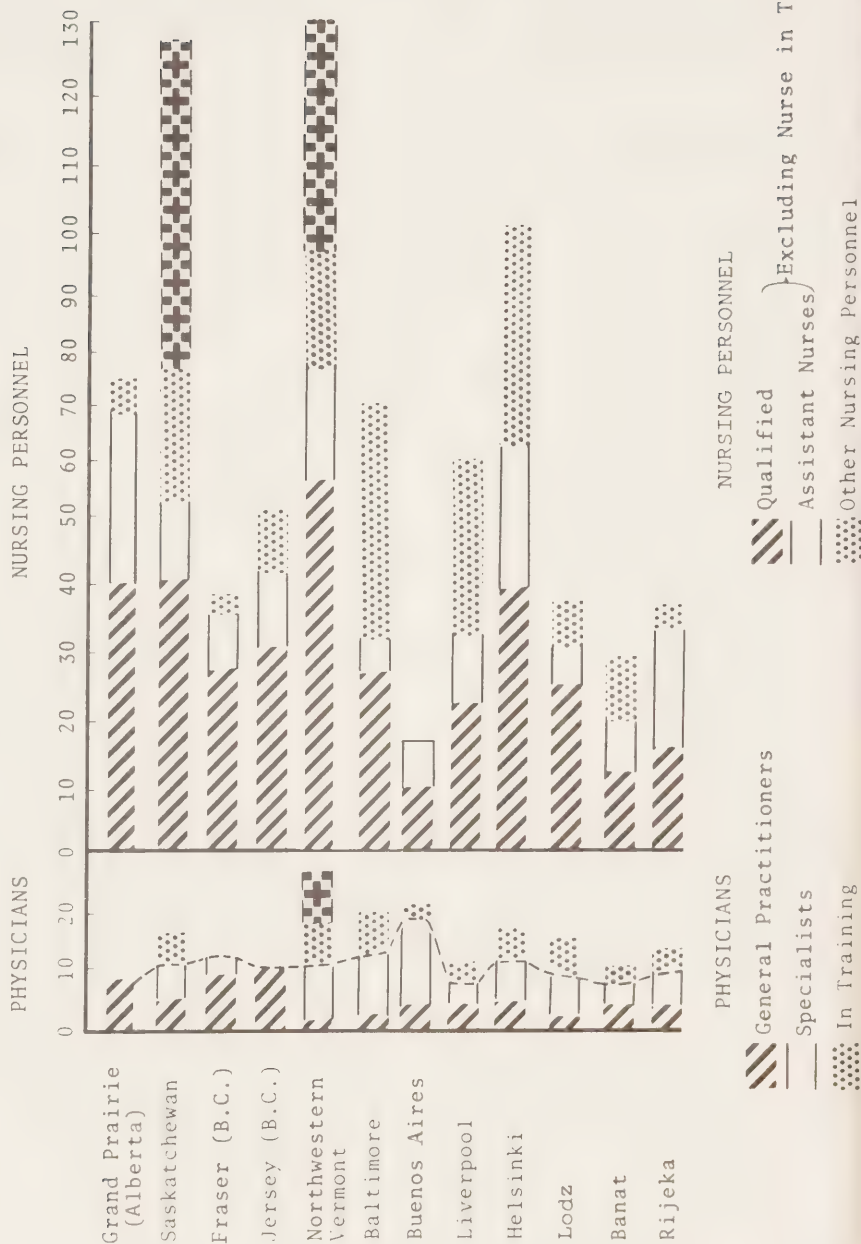
** Armstrong discusses at some length, the high cost of investment in training (said to be \$71,000 for a g.p. and \$125,000 for a specialist) and Canadian savings on training costs through encouragement of health professionals' immigration.

WORLD HEALTH ORGANIZATION/INTERNATIONAL
COLLABORATIVE STUDY OF MEDICAL CARE UTILIZATION

Chart 7

PHYSICIAN AND NURSING PERSONNEL RESOURCES

MANPOWER-RATIOS/10,000 POPULATION



The main questions, then, are how to develop better information collection and how to devise incentives or disincentives to correct the present imbalances.

PRINCIPLES IN DETERMINATION OF LEVELS AND METHODS OF PAYMENT

Glaser⁽⁸⁾ has reviewed systems of paying doctors in 16 countries (but not Canada). His overview of doctors' attitudes to payment may be helpful in understanding why they are not anxious for any changes in the fee-for-service system.

"Professionals usually believe they are underpaid and make ceaseless demands for better pay, more social recognition, and better facilities. Partly this results from the belief of each profession that the problems it specializes in solving are particularly threatening to society, and that society must be eager for salvation at any cost. The scope of these demands results partly from a belief that the government could easily raise all the necessary money by its taxing powers and by budgetary reallocations."

How may an efficient system be designed? Glaser says that procedures for determining and distributing pay are symbolically significant - as important as the amount of money. "Procedures must satisfy any profession's distinctive concern with sharing in all managerial decisions and reserving all clinical decisions to itself. Adequate financial rewards must be combined with satisfying technical working conditions and with the personal appreciation of patients. Therefore once the procedures and levels of payment suffice and if the non-pecuniary rewards are protected, doctors will adjust to any system of compensation. In practice the most familiar system usually arouses the least protest."

"The purpose of medical pay is to motivate maximum effort from the proper physician wherever necessary. Leaders of the profession in every country try to spread and perfect whatever payment methods will service clinical goals and will please their members. They resist procedures that might cause doctors to stint, strike, or flee. If doctors in sufficient number and with enough heat claim the methods and levels of pay are depriving them of motivation and resources, enough laymen will worry about maintenance of care to bring about major concessions.

"Most payment systems in public care schemes are simply those inherited from prior practice, since the doctors would be disturbed by changes. Most payment procedures under 'socialized medicine' are simply more bureaucratized versions of the methods that were used and often even invented by the doctors under earlier private practice. The 'foreign' methods denounced by one country's doctors usually are customarily accepted by the medical profession somewhere else. Some methods of medical payment that are denounced in some countries, such as salaried employment in organizations, may be welcomed elsewhere as preferable to risky conditions in the free market.

"After prolonged periods of financial imbalance or inequalities in the provision of medical care, governments may impose new systems of payment. These changes are rarely as sudden as they appear, nor are they invented by laymen. Usually the plans were discussed long before and were shelved because the government lacked a firm majority willing to override the medical association. Usually the original plans were devised by committees including some doctors, and they were supported by a faction within the medical profession. Even the most authoritarian decrees customarily contain some modifications that would please the medical profession, since the government is anxious about any interruption of medical service for which it will be blamed. Usually the significance of an authoritarian solution is to demonstrate to the medical profession that some system of rules, price ceilings, and orderly budgeting is unavoidable. The precise administrative procedures usually are left to negotiation between the medical association and the public authorities. Once agreements are made and doctors accept the system in practice, members of the professions are assigned to administer it, with the laymen relegated to budgetary review.

"Therefore, authoritarian and evolutionary solutions ultimately end at the same point. Lest medical services be upset and lest they be blamed, the government and sick funds create an administrative structure and system of medical pay that is acceptable to the medical profession. Elaborate concessions are made to the profession's demands for autonomy, resources and incentives sufficient for future recruitment. Standing consultative mechanisms are created. Shortages of money and malfunctions touch off occasional disputes, sometimes punctuated by extravagant rhetoric and strike threats, but almost invariably the doctors obtain

concessions in money and procedure. Since money is limited, doctors rarely get paid as well as they would like, but usually they gain more from the public authorities than does any other private group.

"Certain administrative remedies might moderate these demands. First, the medical profession needs to be informed better about where it actually stands in the nation's income and prestige structure... Medicine ranks very high in salary and prestige in all countries; where its living standards fall below those of doctors in other countries, the reason is poverty in the home country, but doctors usually rank much higher than their fellow citizens. Doctors think they earn less than they do.

"A second remedy is to reorganize the confrontation system."

"There is resistance to the idea that a fee-for-service system should be discontinued", says Glaser, but he thinks that the resisters are often ill-informed about the effects of this discontinuation because theories of wage determination - whether in a market or political economy - "list certain variables that might predict a favourable position for doctors in income and social prestige as medical care becomes more extensively organized. These determining variables are: the occupation's functional importance to the survival and work of the rest of the economy; the amount of skill, responsibility, and preparatory education; the scarcity of the required skills in the economy relative to the public's effective demand; the occupation's ingroup controls over the supply of manpower and over price competition; deference by the rest of the population; and influence with decision-makers. The income and status of the medical profession should decline only if the introduction or expansion of a national medical care system is associated with the profession's decline on these determining variables."

ALTERNATIVES TO FEE-FOR-SERVICE

What are the advantages of fee-for-service, salary and capitation payment systems? Describing fee-for-service, Glaser says:

"How it works in practice depends upon the prosperity and ethics of the medical profession... If a country has a high national income and effective taxation capable of supporting

generous health insurance fees, doctors' incomes may be high ... Regular consultation between the medical association and the public agency are essential to morale and peace. Regional machinery to review rates is necessary to modernize them as the incomes of the doctors' social peers rise.

"Fee-for-service systems have common characteristics: better paid procedures will be more commonly practiced than poorly paid. There is need for constant review of prices against procedures which may become simplified. Failure to pay properly may lead to underdevelopment of some specialties and overdevelopment of others. It benefits surgical specialties more because they can more easily be itemized and priced. Low fees do not inevitably produce low incomes if each doctor can have many patients and do many tasks...

"If the patient pays nothing neither he nor the doctor will thereby be deterred from medically unnecessary work that gives the doctor extra income and gives the patient the feeling that the money he paid in taxes is not wasted." To some extent controls may be built in to discourage unnecessary work but this may discourage justified long-term care. Effective and acceptable administrative controls over venal multiplicity of procedures requires the cooperation of the medical association.

"Under fee-for-service the doctor's income depends on whatever problems patients present to him. Usually patients are not bound to one particular doctor. Therefore, compared to other payment systems, doctors more often must cater to patients."

Alternatives are salaries and capitation systems.

"The possible advantages and weaknesses of salary depend on the traditions and medical organization of the country: salaries can be associated with excellence or with weakness. Hasty care, few home visits, excessive referrals, and other defects occur in some countries but not in others. Certain desirable results - such as non-mercenary attitudes, close colleague relations, interest in personal professional growth, economical care, etc. are certainly not universal in all countries with salaried medicine but cross-national variations exist as a result of tradition, the attitudes of the medical association, the organization of the system, the relation of doctors to resources, and so on. The mixture of part-time salaried practice and part-time private fee-for-service practice can generate serious administrative and ethical

problems that would not exist under any payment system covering the full working day. Probably all salaried practice has the virtue of greater administrative simplicity than fee-for-service and capitation systems. As a general rule, salaried systems do not encourage unnecessary treatment or medically unjustified multiplication of procedures, but the latter is possible in a few systems when doctors earn overtime or can select the amount of salaried work time.

"Since salaries are fixed and publicly known, they invite invidious comparisons between medicine and other occupations, and doctors' pay may become controversial: doctors may press to equal or surpass other salaried occupations; lower ranking doctors may grumble about the better paid; other salaried occupations may complain that their common employer (such as the hospital or the government) favors doctors unduly. Salaried systems easily become targets for discontent.

"Some salary structures are delicately attuned to encourage movements of doctors into certain jobs and regions, and to discourage other career choices. These incentives succeed if they coincide with other rewards and professional values. By themselves, the monetary incentives may not be enough to compensate for undesirable features of jobs and regions. In practice, very large differentials usually are not provided to attract doctors into less popular assignments, because of the need to preserve a rank hierarchy in pay. For example, most countries are short of doctors in rural areas, because few salaried systems violate the rank principle to the extent of placing rural general practitioners higher than most specialists...

"Apparently gross neglect of patients does not occur in any of the countries that have used capitation systems. Certain important countervailing forces protect the patient, such as the individual doctor's ethical conscience, the medical profession's group opinion condemning dereliction of duty, and the danger of official complaints and lawsuits. But capitation results in excessive transfers to services outside the G.P.'s panel practice. For example, the G.P. may refer the time-consuming patient to another organization, particularly the out-patient department of the hospital, unless effective administrative deterrents exist.

"Because of their standardized character, simple capitation fees provide no pecuniary motives for more effort or for work in better quality.

"Capitation tends to reinforce the distinction between G.P. and specialists by depriving each of the financial motives to perform the other's procedures. It survives best where the evolution of medical practice and the aspirations of doctors do not blur the difference. Under pressure from the medical profession, some national schemes have incorporated supplements to stimulate better work or to mollify the discontented, but such revisions illustrate the world-wide trend away from simple capitation."

CHANGES WHICH HAVE ALREADY TAKEN PLACE

Governments are beginning to give indications about the limits of their purses and are negotiating toughly with provincial medical associations about cost of living increments to be added to the payment schedules.

Provincial medical associations are adjusting the rates for various fee schedule items between specialists and general practitioners and have increased the rates for general practitioners.

Anderson and Crichton discovered that the multi-specialty groups in Saskatchewan had developed their own schemes for redistributing the earnings of the group to partners and salaried assistants. The business managers were not anxious to discuss the criteria they used for this redistribution, and the reasons for this are not clear. As the business managers pointed out, medical groups have no legal status. Were they afraid that they would be accused of unethical fee splitting? Were they afraid of revealing their business affairs to rivals? Especially in secondary referral centres, these groups were particularly conscious of the interdependence of the general practitioners and specialists (which had been the reason for forming a group in the first place) and had worked out incentive systems which gave recognition to their joint interests in referral patterns. The business managers were asking that their groups should be recognized as corporate bodies for the purposes of negotiations and taxation.

A few established group health centres have been able to negotiate global budgets with their provincial governments either from medicare funds based on capitation or from hospital insurance funds based on previous annual income-expenditure accounts.

These community clinics have demonstrated that their special concern is to keep patients out of hospital and they employ considerable numbers of support staff to assist them in attaining this objective.

The per diem rates or global budgets of hospitals have often permitted physicians to get hidden subsidies. Anderson and Crichton found that in Saskatchewan the doctors in group practices (and particularly the specialists) were expected by their group not only to make use of the hospital's resources to the maximum extent congruent with the objectives of the group, but also to push the hospital in the direction of their group's interest. This was much easier to do, of course, in rural municipalities where there was no competition outside the group for the use of a particular hospital and where the hospital administrator was co-operative. What was interesting was the lack of communication between the groups' business managers and the local hospital administrators.

PHYSICIANS AS ENTREPRENEURS

One very important fact which the Community Health Centre Project was unable to find out much about was the overall financial position of physicians.

Ruderman⁽¹⁹⁾ attempted to discover from clinic groups, from associations of clinics and associations of clinic managers the levels of income and expenditure of physicians, but without success. Davidson⁽²⁰⁾ too made little headway with his enquiries. Copeman⁽⁹⁾ has described the financial failures of some of the rural physicians who died and others who could not manage to retire because of their possessions being in an unsaleable equity.

The Project team was left with an impression, which may be totally false, that physicians would like to separate their earned income from their investment income. They would like to find methods of financing office accommodations and equipment other than putting in their own capital or taking out loans. This does not mean that some would not wish to invest in laboratories, pharmacies or other remunerative sectors of the health care industry, but they do not see why they should be expected to invest their capital in outlying offices as well as being asked to give service there.

Another impression was created that physicians are more interested in becoming salaried than they were in the past, particularly if salaries carry fringe benefits with them. There are attractions in having contracts of service with large organizations which can offer pensions, paid holidays, paid locums, educational expenses, and other advantages. The immediate income is less important to some than the income spread over time and continuing into old age.

PEER REVIEW AND SUPERVISION

In a discussion of quality control, Hall⁽²¹⁾ says that only two mechanisms have proved effective: "One of these is peer review and the other the appointed supervisor."

"Peer review is essentially quality control by those who are involved in providing the same sort of service. It requires that the worker submit his work patterns to the scrutiny of his fellows, and that he respond positively to their assessment of his work. It also requires, of course, that he also act as judge of those who sit in judgment on him, to play the role that they also play. Where peer review functions satisfactorily it is of course not restricted to a posteriori assessments of the work of the health practitioners. Indeed, its most important function may be of an anticipatory sort, in the sense that workers make use of the judgment and expertise of their colleagues even before they venture on to a task, and also while the task is underway. In this manner peer review can be a formidably powerful device to safeguard and improve the quality of service provided. Moreover the control is put to work where it can be most effective, in the sense that it is internalized continually by those who expose themselves to such control."

"By contrast, quality control through supervision is a clumsy and relatively one-sided sort of arrangement. It is widely used in hospitals where the chief of service and the "head" nurse, for example, have delegated to them the responsibility to maintain specified standards of service. It is their responsibility to formulate the standards and to devise mechanisms for achieving such standards. To do this, they may act essentially as a policing force with power to exact penalties where standards are sacrificed; on the other hand they may devise schemes much like those of peer review in which the workers internalize the standards and which in effect become self-regulating.

"Both of the systems discussed above, however, can operate only where there are several workers involved in the specific service. Neither of them can be used to control the quality of service of the solo practitioners."

The method of quality control in the past was the audit of work of physicians in the hospitals for the purpose of accreditation. All other hospital staff are supervised. Now that more services are being delivered by groups outside hospital, quality control mechanisms need to be reviewed. And consumers are beginning to distinguish between medical treatment and health care. It is quite possible that a nutritionist will have a greater contribution to make to poverty areas than a physician. In certain circumstances non-professionals have been more successful in treating than have professionals. Consequently, the membership of the group of peers is open to challenge. Peer review has to be reconsidered - what are appropriate decisions to be reviewed by physicians alone, physicians with other professionals and professionals with 'laymen'? And how should these review processes be conducted? These matters will be discussed in a later chapter.

SUMMARY

There are two main bastions around which physicians' resistance to change is organized: payment systems and professional discretion.

Physicians expect subsidies, e.g. hospital facilities to be provided for their work or support services such as seconded public health nurses. Hospital privileges are thus, more than a status symbol, they may help to reduce expenses.

Physicians fear change though they realize it must come, and because of their resistances they do not usually initiate new ideas themselves as a professional group but respond instead to government initiatives. Innovators within the profession tend to meet with hostility. In general physicians think that the existing system is good and that changes (and increased government intervention) will lead to more bureaucratic control and red tape.

Blishen has argued that professional ideologies protect against strain. Canadian physicians' ideology is concerned with professional control, freedom, quality of medical care, public responsibility, privacy, personal responsibility, voluntary participation, universal availability.

In Britain, the National Health Service is the only example of workers' control in any major industry. Klein calls it a close syndicalist corporation and thinks it should become an open consumer oriented organization. There is now sufficient experience in distinguishing between qualities of procedures attending a decision (efficiency) and discretionary decisions (effectiveness). But consumers need to be shown what standards to apply to efficiency. Presently these are not at all clear.

The earnings (gross and net) of physicians are reviewed. There is no doubt that existing fee schedules influence patterns of medical practice. There is a high level of hospitalization and of surgical procedures in Canada.

All physicians have profited by government intervention but some more than others. The Canadian fee schedules have been thrown out of gear by the introduction of Medicare and need to be readjusted. More facts are necessary for the Associations to plan these adjustments.

More needs to be found out and communicated to physicians and the public about physicians earnings spread over time. More needs to be found out and communicated about specialization. Some work is being done on specialist/general practitioner mixes. But the World Health Organization/International Collaborative Study of Medical Care Utilization study also raises questions of physician/other health professionals mix.

When information has been collected and disseminated, incentives and disincentives to different forms of practice need to be developed.

Glaser has analyzed various payment systems and physicians reasons for resistance to change throughout the world. He says that physicians do not realize that under general principles of wage determination they are always likely to be well remunerated because they are regarded as having an important contribution to make to society. Doctors will resist change and governments find it easier to stick with existing systems. There are certain administrative remedies for discontent: (a) better information to doctors and public about incomes, (b) reorganization of the confrontation system. All systems of remuneration, whether fee-for-service, salary or capitation have advantages and disadvantages. These are listed.

How all systems work in practice depend upon both the prosperity and ethics of medical professionals. Fee-for-service has need for constant readjustment of prices. It benefits surgical specialties more since they can be more easily itemized. It may lead to unnecessary treatment procedures because doctors want good incomes and prepaying patients want their money's worth. Doctors must cater to patients more than under other system.

Salaries may be associated with excellence or weakness. Salaried systems easily become targets for discontent both for doctors and public. Salary structures may be attuned to get doctors to do less well-liked jobs but if so this financial incentive system will conflict with the status hierarchy in the medical profession of specialists and general practitioners. A mix of salaries and fee-for-service creates administration and ethical problems.

Capitation systems seem to have built in ethical safeguards and patients do not seem to be neglected. But these systems may result in excessive transfer from the panel practices of general practitioners to other physicians (e.g. hospital out-patient service) unless administrative deterrents exist. There are no incentives in capitation for more effort or work of better quality. This system tends to reinforce the distinction between general practitioners and specialists, unless they can work together under the same practice organization.

Some changes have already taken place. Negotiations between provincial governments and medical associations are getting tougher. Within provincial medical associations considerable adjustment of fees between specialists and general practitioners exists. Multi-specialty groups in Saskatchewan have developed their own income redistribution systems. Global budgets have been negotiated by some health centres.

Little was found out about the entrepreneurial activities of physicians but there are indications that they do not wish to invest in practice premises in outlying areas and that some might like to have salaries and good fringe benefits. Quality control mechanisms over professional effectiveness are peer review or supervision. Peer review is more satisfactory than supervision

because it is anticipatory, it is reciprocal, and it becomes internalized. Where there is only one representative of a profession there cannot be peer review. There may need to be supervision by a clinic administrator. Supervision is clumsy and one-sided unless the workers internalize the standards and become self-regulating.

The process of peer review as it now exists has to be reconsidered.

REFERENCES

1. Logan, R.F.L.: Personal communication.
2. Pole, D.: Personal communication.
3. Evans, R.G.: (a) The Impact of Health Centres on Patterns of Hospital Expenditure (b) Community Health Centres and the Cost of Acute Hospitalization in Canada.
4. (a) Badgley, Robin, and Wolfe, Samuel: Doctors' Strike. Macmillan, Toronto, 1967.
(b) Tollefsen, J.: Bitter Medicine. Prairie Press, Saskatoon, 1964.
5. Saskatchewan: Royal Commission on Hospital Privileges (Woods Commission) Queen's Printer, Regina, 1963.
6. Road, D.A.: Personal communication.
7. Powell, J. Enoch: A New Look at Medicine and Politics. Pitman Publishing Co. Ltd., London, 1966.
8. Glaser, William A.: Paying the Doctor, The Johns Hopkins Press, Baltimore, 1970.
9. Copeman, W.: Personal communication.
10. Wilson, R.G.: Health Care Delivery-Physician Attitudes.
11. Smith, Neville H.: Ambulatory Health Care-The Views of a Clinic Physician.
12. Blishen, B.L.: Doctors and Doctrines: The Ideology of Medical Care in Canada. University of Toronto Press, Toronto, 1969.
13. Klein, Rudolf: Accountability in the National Health Service. Reprint: London School of Hygiene and Tropical Medicine, 1971.
14. Editorial Br. Med. J., December 28, 1968.

15. Canada: Department of National Health and Welfare: Health and Welfare Services in Canada, 1972. Research and Statistics Directorate, Ottawa, 1971, pp. 127-129.
16. Armstrong, R.A.: Some Observations on Methods of Physician Remuneration in Canada.
17. Greenhill, Stanley: The Distribution of Available Health Care Personnel and Health Resources in Canada.
18. Logan, R.F.L. et al.: Resources and Systems in International Comparisons of Medical Care. The Milbank Memorial Fund Quarterly, Vol. I., No. 3, Part 2, July, 1972, p. 45-56.
19. Ruderman, Peter: Economic Characteristics of Community Health Centres - Summary and Conclusions.
20. Davidson, W.T.T.: Community Health Centre Project.
21. Hall, Oswald: Allied Health Personnel in Community Health Centres.

THE EXISTING SYSTEM D: OTHER GOVERNMENT FINANCED
SERVICES AND THE PRIVATE SECTOR

THE PUBLIC HEALTH AND MENTAL HEALTH SERVICES

The Canadian Public Health Association listed 31 public health services in 1971.(1)

CHART 8 - CANADIAN PUBLIC HEALTH SERVICES, 1971

- | | |
|------------------------------------|--|
| 1. Maternal | 17. Genetic Counselling |
| 2. Infant | 18. Selective Family Planning |
| 3. Preschool | 19. Dental Services |
| 4. School | 20. Nutrition Services |
| 5. Home Care | 21. Emergency Health Services |
| 6. Communicable Disease
Control | 22. Handicapped and "At Risk"
Registries |
| 7. Rheumatic Fever Program | 23. Laboratory Services |
| 8. Poison Control Program | 24. Mental Health |
| 9. Accident Prevention | 25. Occupational Health |
| 10. V.D. Program | 26. Speech Therapy |
| 11. T.B. Program | 27. Biostatistics |
| 12. Special Needs Areas | 28. Health Education |
| 13. Cancer Control | 29. Sanitation and Environmental
Control |
| 14. Chronic Disease | 30. Voluntary Health Agencies |
| 15. Rehabilitation | 31. Health Centre Construction
Other Considerations |
| 16. Screening Programs | |

These 31 services may be collapsed into eight main categories:

- (a) sanitation, environmental control and communicable disease control;
- (b) accident prevention (including poison control);
- (c) health education services and screening programs;- family health education, school health programs.
- (d) rehabilitation and chronic care programs;

- (e) epidemiological surveys and bio-statistical data collection;
- (f) laboratory services and occupational health services;
- (g) mental health services;
- (h) health centre construction.

The function of the provincial and municipal public health units has not been to diagnose and treat patients, except for those with communicable disease, mental illness, or, in the case of children, dental problems. Instead the emphasis has been on health education, case finding, family advice. In some rural areas they have also provided home nursing and home care services, which are given by the V.O.N. elsewhere.

Many public health nurses believe that they could provide the primary health care services of surveillance, maintenance and restoration, referring only complex cases to physicians.⁽²⁾ Nurses have taken responsibility of this kind in northern and eastern outpost communities particularly when they have been given additional training in diagnosing and in midwifery.

The Canadian public health nurses do not consider that, at present, they are being well used in the metropolitan areas where they may come into conflict with private physicians if they offer a thorough service to mothers and babies. They have often found it easier to work through the schools than directly with families.

The nurses have begun to press for opportunities to be opened to them in community health care services beyond those now available.⁽³⁾ A number of demonstration projects have shown that they can be used in 'expanded roles'⁽⁴⁾ and training programs have been started.

The future of public health nursing seems to lie in their enrolment as members of fully integrated community health teams. But what of other public health officers - physicians, sanitarians etc.? The proposal of a study group in Quebec⁽⁵⁾ is that the local public health units should be moved over as a whole into the second tier level of the proposed new system of community health centres, to the secondary referral centres and they would work out from there. The service would not be contracted but expanded by 30 doctors and 200 nurses from its present size. In Britain, it is planned that the public health nurses (health visitors) should be seconded from the employment of local government

authorities to the health centres to work with family practitioners. Both of these are possible models for Canada, but it may be even better if some method of including them in the direct staffing of a community health centre is also considered.

Coates (6) suggests that "all existing mental health planning in Canada has begun by focussing on the most overt and pressing need, namely for mental hospitalization, and has in successive order introduced general hospital use, prepaid psychiatric services, and only now begins to engage with community services and community planning gaps". The failures of psychiatrists to develop community mental health were discussed in a previous chapter. Presently, the provincial community mental health systems tend to be undermined by the existence of the fee-for-service funding of the rest of psychiatric services.

The links between provincial public health and mental health services and between them and private practitioners are not close, possibly because the physicians do not meet in hospital corridors or other informal work situations. The fee-for-service physicians seem to be threatened by developments in public health or VON nursing, fearing they may lose patients.

REHABILITATION SERVICES: HALF PUBLIC: HALF PRIVATE

Although rehabilitation and chronic care programs appear on the list of public health services, they seem to be a neglected sector of the health care system.

Some provinces have developed a small department to deal with rehabilitation matters which may include a register of disabled persons, funds to pay for prostheses or for other special needs (B.C. has an extensive support service for patients with chronic renal failure), or they may provide consultant services in physiotherapy, etc. But much of the rehabilitation sector has been left to be dealt with by volunteer agencies or by demonstration projects. Many voluntary agencies which have been successful at raising money in the past are finding it difficult to continue to cope with inflationary costs. As well, voluntary organizations may be better at starting new activities than continuing to run well-established projects - pioneers get tired and their successors may not have the same flair.

Home care services are in the rehabilitation sector.⁽⁷⁾ These provide an example of the variety of models which one type of program can offer. There seems to be very little general agreement on what a home care service should offer - some are strictly home nursing services, others provide a complete rehabilitation service of nurses, social workers, physiotherapists, homemakers, etc. The present arrangements seem to be arbitrary, the services have not been compared or evaluated. Some are extensions of public health departments, some are sponsored by mental health, some work out of hospitals.

The present arrangements for rehabilitation were not explored in any comprehensive way by the Project staff, possibly because there is no one agency at provincial level which is responsible for dealing with extended and chronic care, and no major publicly funded program which has rehabilitation as its main task. This is a very confused sector of the health care system.

Yet at the same time, this is the sector where volunteers have been most involved. There are many lessons to be learned about good use of manpower, and in general, tight financing - how to give a lot of service on a small budget.

In most provinces there is a proliferation of voluntary agencies concerned with health and welfare. In the past they tended to be sponsored by upper middle-class subscribers and many sought financial and moral support from the United Appeal.⁽⁸⁾ Others preferred to make their own appeals to the public. Now, however, some subscribers are beginning to ask questions about the necessity for paying taxes for health care and giving donations at the same time so that income for the funds has not risen as quickly as have costs. In general, however, this sector of activity is poorly organized for getting money compared with the medical and hospital associations. The case studies commissioned by the Community Health Centre Project (summarized by New⁽⁹⁾) demonstrate that it is difficult to get funding for innovative programs from sources other than National Health Grants or by mounting a very exciting public appeal and this is not easy to achieve.

The CELDIC Report (1970) provided a clearly stated set of objectives for those voluntary agencies concerned with the rehabilitation of children. The agencies have not yet had enough time to bring sufficient pressure to bear on the provincial governments to attain their objectives.⁽¹⁰⁾

INSTITUTIONS ASSISTED BY HEALTH RESOURCES FUNDS

The health resources funds are now nearly exhausted. They were made available to teaching institutions at a time when there was thought to be a shortage of skilled health professionals. Partly as a result of the health resources funds the shortages do not now appear to be so acute. At the present time attempts are being made to calculate the skills available and how they must be modified to meet future needs.

CATEGORY SERVICES

Statistics Canada (11) reports that other publicly financed category programs are gradually being phased out and integrated into other health or welfare programs, in the form of grant programs as described in Chapter 4.

THE PRIVATE SECTOR

FUNDING

Medicare is, of course, financed quite largely from insurance premiums. It has been described as a public service because it is non-profit and has major contributions from the federal and provincial governments. The amount contributed by the three parties varies from one province to another but insurance payments make up about one-third.

Questions have been raised about the scope of the payments made by the insured group, whether contributions should be increased, or whether the present nominal charges made for services by some provincial authorities should be increased. The federal Minister of Health has indicated that the debate on deterred fees is not over. In Saskatchewan when a 'utilization' fee was imposed by the government, the community clinics developed a prepaid mutual insurance scheme for their members to cover the costs of consultations with physicians which they would otherwise have had to meet.

There are two main ways in which the public has sought solutions to the problems of finding the money to pay for other health care services when needed, apart from drawing on personal savings or seeking welfare aid - the first is to seek coverage from private indemnity plans, the second to seek fringe benefits from employers who will then negotiate with an insurance agency for coverage. The indemnity plans may be specific or general - one may insure against the need for dental care or for drugs, or for payments to cover all additional expenses of illness.

The indemnity and fringe benefit programs appear to have increased the demands for service by patients who are anxious "to get their money's worth". The profit or non-profit insuring agencies do not seem to have considered their effect upon supply and demand for professional services* nor are the schemes very sophisticated in their financial calculations.(12)

At one time, the federal government seems to have been interested in the concept of denticare and the possibility of subsidizing or providing free prescription drugs. However, the experience with Medicare and the movement away from providing category services seems to make these programs less likely to be implemented in the immediate future.

DENTISTRY

MacFarlane and Reid(13) have shown how the organization of dental practice is still very rudimentary and has not changed greatly in the last 10 years. Although "there is general consensus among dental practitioners and others in Canada that the profession at the present time is able to provide about one-third of the total dental treatment service required", the dental profession seems to have been unable or unwilling to change the present patterns of dental practice. Such changes as have been brought about "have been the result of initiative on the part of provincial public health authorities in association with the Canada Department of National Health and Welfare and on the part

* The dentists do not seem to have been able to respond to the increased demand with new forms of organization to increase the supply of care.

of some members of occupations outside the formal control of the dental profession. It is not without interest that in both these cases the new provisions for dental health care delivery service were associated with the expansion of permissible duties of the sub-professional and non-professional members of the dental health team".(14)

The Canadian Dental Association proposed to the Hall Commission⁽¹⁵⁾ "that an age-incremental children's dental program should receive priority when and if a tax supported dental care program becomes a fact in Canada. In general, this has been accepted because of the profession's apparent inability to meet the predicted demands of a free, tax supported, universal dental care program ("denticare").

McFarlane and Reid go on to say: "The members of most occupations and professions in the face of organizational, technical, technological, social, knowledge and other change tend to favour the traditional mode of performing their occupational duties. That the dental profession in Canada seems to have resisted pressure to change its traditional mode of practice should occasion no surprise. There are many reasons for this stance on the part of the members of occupational groups but two of the most important factors which seem to contribute to it are (i) the motivations... for entering and continuing in a particular occupation and profession; and (ii) the auspices and environment under which the occupational and professional skills were acquired". It is suggested that dentists are not only a self-selected homogeneous group of professionals who like to work in "independent" isolation using their manual skills, but that they are also trained in university to take a negative approach to any change in the present system.

PHARMACY

Torrance⁽¹⁶⁾ (a sociologist) has examined the role of the drug manufacturers and retailers in the present health care system: "... the ethical drug manufacturers have had, and continue to have, an enormous influence on the health system. On the positive side, one need only cite the radical changes in morbidity and mortality over the last 50 years due to the appearance of effective new drugs. Because of their contributions, the

the pharmaceutical industry has become a pillar of the medical establishment, a heavy supporter of professional activities, and an influential voice in professional and scientific affairs. However, the situation has less positive features... the ethical drug industry has a strong vested interest in preserving the status quo in regard to the organization of Canada's health service. ... At the moment, much of the industry's high profitability is founded on the isolation and susceptibility of medical practitioners, and the fragmentation of pharmacy services into small inefficient units. The doctors are the targets of a vast promotional enterprise urging them to use drugs heavily and to prescribe the expensive, brand-name products into the bargain. There is much to suggest that this bombardment, along with factors such as defective medical education and controls, leads to a great deal of irrational and unnecessary prescribing and is inordinately costly. At the moment, although it has risen steadily, the utilization of prescription drugs is held in check to a considerable extent by high consumer drug prices. Unless far reaching structural change takes place, the inclusion of prescription drugs under medicare could vastly increase utilization rates and create a cost nightmare - and possibly a therapeutic one as well...

"Despite a recent decline there are still too many pharmacists for prescription demand and highly educated pharmacists are badly under-utilized. The predominant method of charging for drugs in retail pharmacy now consists of the acquisition cost plus a set professional fee. Aside from this problem of high acquisition costs arising from lack of market power vis-à-vis manufacturers, the professional fee is a sham because it bears little relation to the quality of services rendered. Instead it is based on prevailing cost structures, inflated as they are by operating inefficiencies. Great economies can be achieved in the retail pharmacy sector by the further consolidation of outlets and the use of auxiliaries for many tasks. This would also free the pharmacist to put his skills to work in the more urgent areas of providing drug information and monitoring prescribing patterns and patient drug use.

"The present system thus leaves a great deal to be desired from the standpoints both of cost and therapeutic rationality."

Torrance believes that there will be resistance to changes in the system both by the large manufacturers and the community pharmacists. "If the change is sudden and drastic, a vigorous

and bitter opposition can be anticipated... The situation is the product of an unanticipated but mutually reinforcing set of factors. The various groups are ensnared in an irrational reward system whose bad features are not of their conscious making but are the result of circumstances and social change."

Bachynsky(17), a pharmacy consultant at the Department of National Health and Welfare, has provided some data on the existing system of pharmaceutical services.

"There are about 4,850 pharmacies in Canada so that the ratio of population to pharmacies is 4,400: 1.

"The location of the pharmacy is an important aspect of pharmacy service. Convenience has a high value to patients and pharmacies locate either near the physician's office or the patient's home. The area served by pharmacies is increasing, however, with one study showing that 30% of the prescriptions dispensed were for patients living more than two miles from the pharmacy. The fixed convenient location of the pharmacist provides ready access to the public for long hours during the week. This ease of access to a health professional for advice on a wide range of health matters at little expense is often overlooked in health planning.

"Pharmaceutical products sold in Canada are manufactured primarily in Canada. In 1970 the value of manufacturers' sales of pharmaceuticals was about \$330 million. Of this amount, ethical pharmaceuticals (prescription drugs plus over-the-counter ethical drugs) accounted for about \$290 million. The remainder was made up of proprietary products advertised by the mass media and distributed by both pharmacies and other outlets. In contrast to proprietary products ethical over-the-counter products are sold only in pharmacies and are normally advertised only to health professionals.

"In 1970, 55% of the manufacturers' sales of ethical products were sold to drug wholesalers for redistribution, while 45% were sold directly to pharmacies, hospitals and government. Pharmacies purchased \$162 million in pharmaceuticals through wholesalers and \$63 million direct from the manufacturer for a total purchase of \$225 million which was subsequently sold to the public for \$375 million.

"The number of persons served per pharmacy is increasing as the number of pharmacies decline. There tends to be a higher concentration of pharmacies in urban areas. Improved transportation has accelerated this trend."

Martin(18) points out some of the difficulties associated with rationalization - the growth of chain drugstores in which pharmacy forms a very small part of the business, and the vertical integration of manufacturing, wholesaling, and the takeover of ownership of individual pharmacies by drug distribution houses. In another paper Bachynsky(19) puts forward the view that the pharmacist exists apart from the present health care system; his expertise remains largely untapped by virtue of his limited exchange with other health professionals. In particular, physicians rely less on pharmacists than is warranted because they are perceived as lacking in clinical experience. For his capacities to be fully developed, the pharmacist needs to begin to have a meaningful exchange with physicians and to become involved in health education outside the confines of his pharmacy. Martin points out that "criticism and comments on the present occupational role of the pharmacist boils down to the issue of the fit between his professional education and the reality of his occupational activity." It is often alleged that "the pharmacist is either over-educated or under-utilized in terms of the demands of his work role. In fact, the pharmacist may be under-educated in terms of the role that he could assume."

SUMMARY

PUBLIC AND MENTAL HEALTH SERVICES

There are eight main categories of public health service which may be given by Provinces or municipalities: sanitation, environmental control and communicable disease control, accident prevention, health education services, rehabilitation and chronic care services, epidemiological surveys and data collection, laboratory and occupational health services, mental health services, health centre construction. Public health departments treat only communicable diseases, mental illness and dental ill health in children though they may provide a nursing and midwifery service in some outlying areas. Their main function has been health education and case finding.

Nurses would like to make more contribution to community health services.

What would be the best way to attach public health nurses to community health services? Public health and mental health have not so far worked well together, nor do they have close relationship with private practitioners.

REHABILITATION SERVICES

Rehabilitation is a neglected sector of care in which public health and voluntary agencies have developed experimental or local projects. This sector of health care is very confused. But it is the sector where volunteers have been used and it should be possible to draw on experience about good use of manpower and tight financing.

Voluntary agencies manned by middle-class volunteers have made a considerable contribution to health care in the past. Now people are questioning the need to contribute to them and to pay insurance and taxes. New agencies have difficulty in getting start-up funds.

The voluntary agencies have made a very considerable contribution through developing the CELDIC Report. However the impact of this report has not yet been seen.

OTHER GOVERNMENT FINANCED SERVICES

Health resources funds are almost exhausted but there now appears to be less of a shortage of manpower.

Category services financed by government are now being phased out. Those in need of help are being encouraged to apply for standard medicare or for welfare assistance (e.g. blind persons).

Medicare is financed, about one-third, from insurance contributions. The possibility of making 'utilization' or 'deterrent' charges is still there. Federal government seems to have abandoned the idea of providing denticare and subsidized pharmaceutical prescriptions, for the present.

The public uses insurance whether self-paid or employer-paid to meet extra charges for health care needs; dentists, drugs, hospital extras, sick pay. They want to get their money's worth. Neither the insurance companies nor the professions are well organized to deal with these additional programs, which have increased the demand for hospital care, dental care and drugs.

The dental profession seems to be unable to organize more effectively to respond to additional demands and their present training does not help.

The drug manufacturers have a strong vested interest in preserving the status quo. Physicians are not good at prescribing for they find it difficult to sort out information about drugs. The pharmacists are isolated in their stores and do not have much communication with the prescribers. The present system leaves a great deal to be desired from the standpoints both of cost and therapeutic rationality. Pharmacists could make a better contribution to health care if they were trained differently and utilized more effectively.

REFERENCES

1. Canadian Public Health Association: Report of the Public Health Practices Committee, April 1971.
- 2a. Churchill, M.P.: The Role of the Nurse in Community Health Centres.
- b. Kergin, Dorothy: Nursing: Community-Related Personnel, Attitudes and Projects.
- c. Splane, Verna: Summary, Nurses Seminar.
3. Department of National Health and Welfare: Report on a Conference on Assistance to the Physician. Health Manpower Planning Division, Health Resources Directorate, 1971.
- 4a. Jones, Phyllis E.: The East York Public Health Nursing Project. Can. J. Public Health, Vol. 60, June 1969, p. 242-246.
- b. Hutchison, D.A. and Dorothy Mumby: Public Health Nurses Work with Family Physicians. Canadian Nurse Journal, Vol. LXVI, Jan. 1970, p. 28-31.
- c. MacArthur, Christine: New Challenges for Visiting Nursing in Nursing Clinics of North America. ed. by D. Kergin, Vol. VI Sept. 1971, p. 368-72.
- d. Jones, Phyllis E.: Community Nursing at Sunnybrook. Can. J. Public Health, Vol. LXII, Sept.-Oct., 1971, p. 368-72.
5. Recommendations du Groupe d'étude sur les unités sanitaires. University of Sherbrooke, mimeographed 1972.
6. Coates, Donald: Mental Health Aspects and Primary Health Care.
7. Reports on a number of home care programs in Quebec and Saskatchewan were received by the Project Office.
8. Govan, Elizabeth S.L.: Voluntary Health Organizations in Canada. Royal Commission on Health Services, 1966, Queen's Printer, Ottawa, Canada, 1966.

9. New, Peter: Community Health Centres: Five Danger Signals
10. The Commission on Emotional and Learning Disorders in Children: One Million Children. L. Crainford, Toronto, June 1970.
11. Canada: Dominion Bureau of Statistics.
- 12a. Hunt, A. Murray: Summary: Seminar on the Dentist, Dental Practice and Community Health.
- 12b. Hlynka, J.L.: Summary: Seminar on Pharmacists' Roles.
13. MacFarlane, Bruce A. and Reid, Angus E.: The Dentist, Dental Practice and the Community Health Centre.
14. Canada: Department of National Health and Welfare. Report of the Ad Hoc Committee on Dental Auxiliaries. Ottawa, Information Canada, 1970.
15. Canada Royal Commission on Health Services (Hall Commission 1964-65, Vol. I-II, Queen's Printer, Ottawa.
16. Torrance, George M.: The Influence of the Drug Industry in Canada's Health System.
17. Bachynsky, J.: Existing System of Pharmaceutical Services.
18. Babson, J.H., Sutherland, R.W., Martin, D.L., Nightingale, D.V.: The Community Health Centre.
19. Bachynsky, J: Background paper: Pharmaceutical Services.

CANADIAN OBJECTIVES AND HEALTH CARE

The struggles between federal and provincial governments are frequently struggles for resources to be used for specific purposes. And the objectives of federal and provincial governments are frequently not the same. Thus the objectives of federal government, which must be to strengthen Canada as a whole, may be in direct conflict with those of the richer provinces which may wish to keep their own resources within provincial boundaries and not to share them with the poorer provinces. Some provincial governments are committed to socialist objectives, others are entrepreneurial in orientation. Biculturalism - bilingualism is another complication. Yet, whilst there are many differences between provinces in what they want to achieve and problems they have to solve, there are also many similarities. Both richer and poorer provinces have high levels of unemployment and unemployment brings many other problems in its train. Most of the provinces have quite large racial minority groups. There are, as well, problems for all provinces of physically disabled, mentally disordered and delinquent minorities who must be supported or controlled by the rest of society.

Although the concepts of health and health care are important values for Canadians, there are other values too. Although the costs of health care have become an important political issue, they are not necessarily the most important issue. For example, the Liberal Party⁽¹⁾ campaigned on the concept of a just society for Canada in the last election and what this phrase meant for federal-provincial relationships was explained by Prime Minister Trudeau in April, 1968. "I feel a just society would have to solve the problem of regional economic disparities, for instance, which means that people who live in regions which are underdeveloped have a claim against the whole of the society to be able to attain in some way average standards of welfare and growth, in order for the society to be just."

Since the Second World War, even those societies most attached to the ethic of private enterprise have come to realise the necessity for some measure of social planning. A society may be weakened if it has developed unevenly, so that large sectors of the population feel the need to protest against injustices whether real or perceived. There are seven main

interlocking areas which 'welfare state' countries have identified as important for developing "a just society" - child socialization education health, housing and environmental planning, availability of employment and leisure; social security; and tolerant race relations.

Some of the provinces are committed to 'welfare state', and social planning objectives, for ideological reasons, others would like to see more social planning for entrepreneurial reasons. For more planning could improve national use of resources; diminish wastefulness. It is not always possible to distinguish means and ends in health care policies. It seems to be clear that the Hospital Insurance and Diagnostic Services Act, 1957, provided many jobs, first for construction workers and later for health service personnel. The overall number of hospital employees in Canada increased by 90% between 1957 and 1967. As well, the building of hospitals in small towns must have had many direct and indirect effects upon local business activities.

Because the federal government has a general responsibility for taking any actions which may strengthen Canada as a nation, it may have been entirely appropriate to redistribute tax moneys without too much specificity about objectives, but it seems certain that there was at first little concern about the measurement of improvements of health outcomes as a result of this investment in health service resources. By 1969, however, politicians were beginning to ask whether they were getting satisfactory returns in improved health of the population for money supposedly being spent on health care. The Task Force groups⁽²⁾ concluded that they were not.

Klein⁽³⁾ in a paper written for the project, discusses the way in which governments are concerned with administrative visibility and political salience. Because of this, he says, they find it difficult to come to grips with a precise statement of objectives. Using the British Hospital Plan of 1962 as an example, he says: "The priorities throughout are expressed in terms of the number of beds, not in terms of what the output of this resource investment was expected to be. The first was easily quantifiable - and so administratively visible, and clearly comprehensible. The second, although much more crucial, lacked this quality of visibility and was therefore ignored."

It would appear that the present interest in community health centres is related at least in part, to the politicians'

and the administrators' concern for improved co-ordination of services and better use of funds. It is also a visible and politically salient topic.

SOCIAL DEVELOPMENT

In a paper prepared for a Canadian seminar in 1967, Trist⁽⁴⁾ pointed out that a number of societies were now able to think about development of opportunity not only for individuals but for a number of different social groups - family, school, workplace, local community and were planning other services and amenities which determine the 'quality of life'. "Welfare rights are starting to be perceived also as development rights ... Emphasis is no longer so much on minimum standards as on the realization of potential, both for the sake of the individual and society."

"There is small chance of policies which will meet the gathering dangers either being formulated (or accepted) or of adaptive institutions being built to implement them effectively or evaluate them convincingly until the present confusions over the obsolete meanings and relations of welfare and development are replaced by new appreciations which express their interdependence and complementarity."

Using organizational theory, Trist puts forward a diagram (Chart 9) explaining the adaptive post-industrial society.

"Both the U.S. and Canada are entering crisis conditions in the confrontation of their underdeveloped parts", says Trist. "The extent, magnitude and heterogeneous nature of these parts are only now in the process of being fully disclosed, while it is becoming apparent also that the qualifications required for entry into the developing parts of these societies (as of other advanced countries) are rising."

CHART 9

CHANGES IN EMPHASIS OF SOCIAL PATTERNS IN THE TRANSITION TO POST-INDUSTRIALISM

Type	From	Towards
Cultural values	achievement self-control independence endurance of distress	self-actualization self-expression inter-dependence capacity for joy
Organizational philosophies	mechanistic forms competitive relations separate objectives own resources regarded as owned absolutely	organic forms collaborative relations linked objectives own resources regarded also as society's resources
Ecological strategies	responsive to crisis specific measures requiring consent short planning horizon damping conflict detailed central control small local government units standardized administration separate services	anticipative of crisis comprehensive measures requiring participation long planning horizon confronting conflict generalized central control enlarged local government units innovative administration co-ordinated services

Source: Trist, Eric: The Relation of Welfare and Development in the Transition to Post industrialism⁽⁴⁾.

Trist's notes: The terms used are intended to be self-explanatory but reference may be made to McClelland (1960) on achievement; Maslow (1954) (1967) on self-actualization; Tomkins (1964) on the regulation of negative affects (such as distress) and positive effects (such as joy). The need to regard corporate resources as belonging to society as well as the corporation became a major theme in A Statement of Company Objectives and Management Philosophy (Shell Refining Co., London 1966).

The concern of Canada, he suggests, should be to develop social plans which permit the adaptive society to emerge. The emphasis in this model is upon processes rather than outcomes. This is the model of the U.S. neighbourhood health centres, developed under special federal grants from the office of Economic Opportunity. These anti-poverty programs were first designed to combat poverty, not ill health, and in the beginning it had not been intended to develop a health centres program, but public pressures grew until the demand had to be met. Rein(5) has described the philosophy underlying the O.E.O. schemes in America and concludes that they focused on the economic and social objectives of social policy rather than the social objectives of economic policy.

It has not altogether been clear which of these two approaches described by Rein has been adopted in Canada. The Speech from the Throne(6) in September 1968 declared:

"The objective of a just society must always include the pursuit of a prosperous economy as well as the fair distribution of its proceeds. Unless Canada can maintain an economy that is efficient, competitive and productive in relation to the most advanced nations on earth, we cannot have a basis for a society from which poverty has been eliminated, we cannot maintain high levels of employment and income and we cannot ensure the standard of life to which Canadians generally aspire."

This stresses the social objectives of economic policy.

In many provinces, however, more attention has been given to the economic and social objectives of social policy. The building of small rural hospitals provided many work opportunities but did not necessarily add much to Canada's productivity, and the uncontrolled relationship between immigration, training opportunities and job opportunities for health professionals seems to indicate that social policies are perceived to be as important as economic policies, at least in some areas and at some periods by some Canadians.

THE BACKGROUND: CANADIAN VALUES ABOUT HEALTH CARE AS EXPRESSED
IN NATIONAL STATEMENTS

In 1964, the Hall Commission - the Royal Commission on Health Services - produced a Health Charter for Canadians⁽⁷⁾. This charter was said to be setting objectives (or aspirations):

"The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions. These objectives can best be achieved through a comprehensive, universal Health Services Program for the Canadian people;

- implemented in accordance with Canada's evolving constitutional arrangements;
- based upon freedom of choice, and upon free and self-governing professions and institutions;
- financed through prepayment arrangements;
- accomplished through the full co-operation of the general public, the health professions, voluntary agencies, all political parties, and governments, federal and municipal;
- directed towards the most effective use of the nation's health resources to attain the highest possible levels of physical and mental well-being".

The Commission went on to define the words used in this charter and recommended:

"That as a nation we now take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind." After stressing the individual's responsibility for his own health and that of his own family, the Commission went on to recommend that "the individual must assume responsibility for wise and prudent use of health services. it goes without saying that, since all resources are scarce, it is the duty of the individual, as well as of the practitioner

prescribing them, to see that the services are used with prudence and economy." The Commissioners went on to warn that individuals would have to pay not only for direct provision of health services but also for health professionals and research into "knowledge of life and disease processes."

Gradually, during the next eight years, it came to be seen that it was not easy to keep the promise "to make all the fruits of health sciences available...without hindrance of any kind."

The principal problem was that of cost. The Economic Council of Canada pointed out in its 1969 Report(8) that spending on health and education services was rising so fast that if it were not levelled off in the near future all of Canada's GNP would be taken up in providing these services at the end of the century.

The Task Force on the Cost of Health Services was set up in 1969 when the federal government had begun to realize that the objectives set down by the Hall Commission were going to be much more expensive than had originally been anticipated.(2) The members were asked to "enquire into ways of restraining the rate of increase in health services expenditures". In the report it was recommended that governments should take the lead in planning, setting standards, and encouraging research and education in health care. They should "concentrate on organizing health facilities and services into effective, efficient and economical systems of comprehensive health care available to all... Only government commands the financial and organizational resources, and the authority, to undertake the required changes."

A partnership between the voluntary and public sectors should be developed to eliminate the lack of co-ordination among health and welfare agencies. On the one hand too much money was being spent on in-patient hospital services and on the other, too little was being directed to "programs for the elderly, for low-income groups, and for other disadvantaged sectors of the population."

The first National Health Manpower Conference was held in 1969(9) and a second in 1971(10). At the first conference the summarizer identified three urgent problems: (a) the need to develop varying demonstration models of primary health care programs in order to get experience of involving allied health

professionals as part of a team providing primary care; (b) the need to develop programs for training individuals in the fields of management, planning, research in health care, and evaluation; (c) the need for improving continuing education in the health services.

The summarizer also drew attention to the maldistribution of health professional manpower and the need for a committee to be set up to study priorities and trends - to establish knowledgeable forecasts of future health needs - using a permanent secretariat and having a research committee to advise on priorities for research support. It was not possible "to secure agreement on guidelines for planning delivery of total health services during the next decade; to determine the numbers and quality of health manpower required for these services; or to plan the education of the required health manpower" at that stage, for a great deal more information was required and there were no easy solutions.

At an intermediate conference in 1970, Assistance to the Physician was considered(11a), and subsequently a special committee of enquiry was set up to report on the more effective use of nurses and other health professionals in community health care(11b).

At the second Manpower Conference, following a recommendation from the first meeting, the Minister announced that he was going to form a Canada Health Council, but no details were given. The Conference recommended that the Council should be non-political and have no executive powers. It should provide continuing support in the areas of assessment of health care needs, health manpower requirements, educational programs and information collection and dissemination. It should sponsor workshops and expert studies on evaluation, transferability, licensing, certification, accreditation and co-ordination of health programs.

Provincial councils should be formed to implement delivery and to study health problems unique to their jurisdiction.

Liaison between educational bodies, professional societies, consumer representatives and local health authorities should be improved.

There were also a number of specific problems relating to licensing, the full use of trained workers and their transferability throughout Canada. Immigrants with skills were not always being well used.

Some method of control of medical careers to adjust to the needs of Canadians must be achieved. Some are underserved whilst there is a great waste of professional specialist skills.

It was also recommended that the federal government should "indirectly support the production of a series of community health centres as demonstration models with suitable combinations of health personnel remunerated in such a way that the incompatibilities of fee-for-service and salary are overcome. The location of centres should be carefully selected - some in deprived city areas, some in rural areas. Built into some at least of these should be the Crisis Centre screening procedure".

In September 1969, the Science Council of Canada asked Dr. H. Locke Robertson⁽¹²⁾ to survey the state of health care research in Canada for the Health Sciences Committee. This committee had been set up "to enquire into the use of science and technology in the Canadian Health Industry and through this to examine the purpose and priority of health science research."

Robertson's group has now made a progress report. In this unpublished report, he begins by saying that it was "assumed at the outset that a national objective, basically a comprehensive and co-ordinated system of health care, has been set."

Robertson believes that a distinction should be made between biomedical health care and social research, and concentrated on the second of these: "the ways and means of delivering health care and research into the health system itself". His review considers the information available about the measurement of health, the measurement of health care standards, the measurement of quality of the system, the people involved in health care, the organization of the system, the cost and management and what was being done to improve efficiency, the use of computers and other automated information systems, the problems of prevention and promotion. He makes recommendations about research in health care:

- "1. Information about health, essential for the proper planning of Health Care, is at present insufficient.

2. The position would be improved if all available information were brought together.
3. Further useful information could be obtained by survey. Recommend a Canadian Health Survey.
4. Research is required to identify and develop ways of obtaining data that will increase capacity for measuring quality of health".

Robertson is not anxious to reduce effort on biomedical research but to increase effort in health care research which, he says, is presently quite limited in scope.

STATEMENTS IN PROVINCIAL REPORTS

Over the years most of the provinces have felt it to be necessary to prepare reports on their own health services. There is a long tradition of reporting in Saskatchewan which includes the Sigerist Report, 1944⁽¹³⁾ and the Thompson Report, 1962⁽¹⁴⁾. The fate of the latter was to get caught up in the Medicare dispute and since then the government seems to have become more cautious about publication, though it commissions private documents for government consumption.

The most recent detailed analyses of health care needs and resources are the reports published in Ontario and Quebec. To summarize these reports may seem to imply that the other provinces have not been active. This is not so, but they have not made such comprehensive studies and printed them for general circulation. In British Columbia, for example, a Health Resources Council was set up and has produced several mimeographed technical reports.⁽¹⁵⁾ In Cape Breton Island, Kates, Peat and Marwick⁽¹⁶⁾, a firm of management consultants who were advising a regional committee set up in 1966, received a National Health Grant for a demonstration project. Other studies have been made in Newfoundland, Nova Scotia, New Brunswick, P.E.I., Manitoba⁽¹⁷⁾ and Alberta.

In Ontario, two committees, the standing Council of Health and an ad hoc committee on the Healing Arts studied health matters simultaneously. Both reported in 1970⁽¹⁸⁾.

The reports of the two Ontario committees provided a comprehensive survey of the health needs and the resources available to meet these needs in the province. The committee on the Healing Arts affirmed that "health is a 'right'" but went on to say that no rights are absolute or static. "The attitudes of society towards what is necessary, desirable or 'adequate' shifts from year to year, and from decade to decade as changes occur in incomes, technology, tastes, expectations and social values. Our desire is to see that public needs are met fully in the long run through most urgent public requirements for health services in the short run are met through efficiency in the utilization of available resources. Hence our primary concern is with the organization and structure of the health industry required to meet social needs." The committee said that it had been much easier to determine broad objectives than to reach agreement on the means to achieve them but they proposed that the following criteria should be used: "maintenance of quality of services, accessibility of health care, co-ordination of services, flexibility, economy and complementarity of services, and a maximum degree of freedom of choice consistent with public safety."

The voluminous report of the committee on the Healing Arts described the setting and framework for the analysis of Ontario's health care system and then went on to review the various healing disciplines with particular emphasis upon problems pertaining to educational and regulatory arrangements for each group before turning attention to the totality of the health care system and an analysis of the problems thought to be most significant in the determination of the future of health care in the province. The recommendations focused in turn upon each of the professions and the regulation of their work, then went on to propose that there should be regional planning of the hospital system, reexamination of the organization of mental health services, development of incentives and training programs for more primary care physicians and a proper examination of "group practice including studies of comparative use of paramedical personnel, comparative incomes and expenses of physicians in groups and other practices, the relationship of practice in groups to the cost of hospitalization and many other such matters."

In 1970, after four years of work, the Ontario Council of Health produced its first report and nine supplementary documents. These supplementary documents on health care delivery

systems presented reviews of a proposed system of regional organization, the implementation of a health statistics system, the role of computers in the health field, library and information systems and examined the need for family physicians for the province and the assistance which nurses might provide to them. There were special studies of laboratories, dental care and rehabilitation services and a review, with 93 recommendations on the delivery of community health care. Many of these recommendations were concerned with developing the family physician service by focusing upon problems of distribution of physicians, improved training for their work, incentives to go to under-serviced areas, and different mixes of specialists (medical and others) in health care teams. Furthermore, a study of the role of the nurse and development of payment mechanisms for services provided by nurses was recommended. It was suggested that an investigation of contractual obligations of physicians and dentists in health teams should be instituted and that closer links between public health and visiting bedside nurses, trained medical social workers and primary care physicians should be developed.

Community health teams should be encouraged by the provision of financial and resource support. Payment mechanism should be reviewed. This support should be directed towards the development of existing services where possible, rather than new services. Universities and community colleges should get together to clarify job specifications and training programs for health workers likely to be working on community health teams. Business management principles should be applied to their organization. The distribution of these centres throughout the province should be carefully examined in consultation with representatives of the various health professions, consumer groups and districts of Ontario. High priority should be given to the establishment of these centres and the principle should be accepted that the ownership of health centres may reside either in the public or private sector provided that there was a continuing assessment of the nature, availability and quality of the services. The report on rehabilitation services tends to be concerned with specialist units and consultancy and has nothing to say about the function of community health teams. Local health departments should provide better preventive care.

The Castonguay-Nepveu Commission, which reported in 1971-72⁽¹⁹⁾ reviewed health, social welfare and income security services in the province of Quebec. In that province, health and

welfare are integrated into one department and although there were two separate committees considering health services and income security the scope of the former was clearly influenced by the latter. The first recommendation of the health committee shows this shift in orientation: "That the general objectives of Quebec's health policy be:

- (a) to improve the state of public health through comprehensive medical care with emphasis on the individual,
- (b) to improve the state of the environment in which the population lives."

Specific objectives were accessibility, acceptability and efficiency in developing a system of high quality care judged by scientific, humane and social standards.

There were to be three fundamental hypotheses in the scheme for reorganization:

- "(a) that the system of dispensing care be defined in terms of its primary task: the realization of the concept of comprehensive medical care;
- (b) that the system of dispensing care be an open one, viz. using all the resources available in the community and responding with care adapted to the people's needs;
- (c) that the system must be sufficiently flexible to reflect changing needs of the population and to adapt itself constantly to prevailing circumstances."

The main principles to be applied to reorganization were the determination of levels of care, the establishment of health centres and regional organization into a three-tiered system of general, specialized and ultra-specialized care. Within the general framework of health policy, health care programs should be established with a view to lowering the hospitalization rate for the treatment of acute illnesses, and increasing the utilization rate of general care and developing particularly, consultations on health education, prevention and detection. Mental health services should be integrated with physical health services.

Health teams were to be promoted so that good use should be made of skills and comprehensive care provided. Care in the local community should be very personal and relevant to the natural environment. Specialist care should be arranged so that quality is improved by greater volume. Three types of health centres were to deliver this care - the local health centre would give general care; the community health centre for general and specialist care would replace the general hospital concept; and the university health centre would provide tertiary care. Health regions should have at least 600,000 population, the existence of at least one university, and the capacity to provide a relatively complete range of care. However, attention should also be paid to distance, travel time and transportation facilities, population distribution in relation to existing health facilities, regional loyalties, administrative regions, present personnel and facilities. The present health units should be integrated into the new scheme and solo practitioners should affiliate with a community health centre.

The public should participate in a consultative capacity in the local health centres at periodic meetings. The management of health centres should be gradually decentralized.

The report goes on to describe in greater detail how the system should be developed administratively with three regional district boards responsible for grouping existing services. The District Board of Health, a public corporation, having 17-20 members should have an absolute majority of members who are not medical professionals, and should act as a board of management, appointing an executive committee if necessary.

The District Boards of Health should have three branches: a planning and research branch to develop regional health programs and, in co-operation with universities, to evaluate results and to co-operate with the department of health in its operational research and applied research projects; a health services branch responsible for operational activities; and an administrative branch to provide support functions. In the planning and research branch there should be a department of public health to study the environment and develop preventive activities. The Health Department of Quebec should also gather information about health needs in the province by continuing enquiries into the general state of public health and specific enquiries as indicated, by keeping provincial registers of certain diseases, deaths, accidents and congenital malformations and by compiling information about personnel and resources and

operation of the health care system. Standards of competence should be established. Incentives for staff to improve the quality of their service should be introduced and payment systems should be reviewed giving attention to subsidies at present not clearly recognized. Health service, teaching and research costs should be distinguished clearly.

Quebec has passed three Bills through the legislature during the summer of 1972: to implement (with a few administrative revisions) the Castonguay-Nepveu Report, to enact a new professional code and to revise the Medical Act.

STATEMENTS IN SPECIAL INTEREST GROUP REPORTS

In addition to the federal and provincial studies, a number of special interest groups have been working on problems of particular concern to their associations. For example, the Canadian Public Health Association⁽²⁰⁾ reviewed public health practices and suggested a number of changes which might be made, including three recommendations on health centres; "As the official community health agency, it is the responsibility of the public health department to give leadership and encourage the construction of health centres with the ultimate ideal that these centres offer a spectrum of preventive and therapeutic services. These centres should be designed to house public health, mental health, voluntary health agency and various consultant personnel. Physicians and perhaps dentists in private practice might also be accommodated so that the services of various community resource personnel can be made more readily available to them". It was suggested that provincial health departments should embark on a construction program.

Another important interest group report was that of the Committee on Emotional and Learning Disorders in Children (CELDIC) 1966-69.⁽²¹⁾ This committee examined the problems of handicapped children as students, patients, wards and offenders and made a number of proposals for giving adequate help to the one million children thought to need help. The committee pointed out that there were problems in the medical model of helping. There was need to share the responsibility. "The adoption of the medical one-to-one relationship as the model for practice in the human service profession has tended to aggravate the acute shortage of personnel because it has given preferred status to those who work with individuals... Individual work with patients in private

practice has become the symbol of status in psychiatry, social work, psychology and even psychiatric nursing... This model of high quality work with a very limited number of persons may be satisfying to those providing professional service but this restricted intake leaves the large majority of persons without any source of help... The adoption of the medical model logically leads the professional into the position of doing 'to' or 'for' the person in need of help rather than 'with' him and maintains a superiority/inferiority in the helping relationship. Yet contemporary society is no longer accepting authoritarian or paternalistic attitudes on the part of those providing educational medical or social services...

"In its search for solutions society must be continually alert to the danger of the development of professionalism instead of professional competence... Some of the more creative and hopefully successful initiatives...are based on a community involvement... This is not unrelated to the current practice which involves the consumer of service in active participation. Far from reducing the visibility of problems, such organization focuses attention on them and stimulates action and mutual help..." The report goes on to argue that social action to create awareness of problems is not enough without 'complicated and laborious' follow-up by planners and implementers of change and those invested with political authority must act to prevent dissatisfaction and feelings of helplessness.

AGREEMENTS AND AMBIGUITIES

In all the reports, the wish was expressed that there should be a more comprehensive system for delivering health care. More recent reports have suggested that regionalization of services might be the method adopted to achieve improved delivery of health services. Seven reports suggested that community health centres should be developed to improve primary care. (Chart 10) Four wished to see more emphasis on family practice or a core curriculum, and three wished to see physicians' assistants allowed to practice. Although four groups recommended that more skilled manpower be trained, the others did not believe this was necessary (with the exception that three groups thought that more health planners and health care researchers were needed.) All thought more research needed to be done.

COMMON RECOMMENDATIONS OF CANADIAN REPORTS

	Composition	Comprehensive Scheme	Regionalization	Quality	Physicians' Assistant	Education	National Health Council	C.H.C.*	Research in Health Care Manpower Delivery
Hall	Lay 3 Nurse 1 Med. 11 Dentist	Yes	No	No	No	M.D. crash programs. Chairs of General Practice	Health Planning Council of Canada	No.	More Yes
Nepveu-Castonguay	2 Med. 8 Lay	Yes	Yes	Yes	Yes Nurses B.Sc.	Detailed M.D. Nurses, etc. Core curriculum	No	Yes More	Yes
Healing Arts	Lay	Yes	Yes	Yes	Yes Postgraduate training nurse	Students in family practice units. Expansion of courses for para-medicals	No	Yes More	Yes
Ontario Council of Health	Gov't 1 Lay 8 Med. 5 Nurse 1 Dentist 1	Yes	Yes	Yes	Yes several options: Medical assistant, public health nurse, reg. nurse, outpost nurse, midwife	Core curriculum	No	Yes More	Yes

CHART 10 (con't)

COMMON RECOMMENDATIONS OF CANADIAN REPORTS (con't)

Composition	Comprehensive Scheme	Regionalization	Quality	Physicians' Assistant	Education	National Health Council	C.H.C.* Manpower	Research in Health Care Delivery
Task Force on Costs	Fed.Govt. 6 Prov.Govt. 19 (all Med.) Nursing 63 Admin) Lay. etc.)	Yes	Yes	Cautious study needed	Economics of health training in health sciences curricula. Centralized training in programs in province	No	Yes	No
1st Manpower Conference	200 + all areas (govt. & professional) represented	Yes	No	No	Flexible	Yes	No	Need for planners etc. Nil on Medical Manpower
2nd Manpower Conference	200 + all areas (govt. & professional) represented	Yes	Yes	No	Continuing	Yes & Provincial Health Councils	Yes	Control
Canadian Public Health 3, Nursing 1, Sociology 1, Practice Education 2. Committee	Public Health Yes 3, Nursing 1, Sociology 1, Practice Education 2. Yes	Yes	Yes	No	More Emphasis on Public Health, National & International School of Public Health	No	Yes	No
CELDIC Committee	Voluntary Associations	Yes	Yes	No	of non-professionals	No	Yes	Use of non-professionals

*C.H.C. - Community Health Centre
Adapted from chart of J. Amy: Science Council, October 1, 1971.

The concepts of regionalization, community health centres, assistance to the physician, planning, research were not very well defined by most groups nor were primary care, family practice or core curriculum. But it is clear that all these concepts are linked in the minds of those who wish to see changes in the present system of health care delivery.

SUMMARY

The problems of funding health care are not easy to resolve because they are related to problems of Canadian pluralistic values, redistribution of taxes and the powers of federal and provincial governments. Quebec particularly has made it clear that it does not wish to accept federal cost-sharing proposals but prefers block grants rather than category grants.

On the other hand the federal government wishes to maintain its momentum in bringing about social change and improvements in health care for the Canadian people as a whole.

The objectives of federal and provincial governments are frequently not the same. Not only do political parties differ in their objectives but the provinces identify different priorities in developing social and other subsidized services to meet the needs of their residents.

The federal government's concern to strengthen Canada as a nation leads to concern with inequality but there is also concern for economic growth. Although health care is an important value it is not necessarily the most important perceived need of Canadians.

Social development in the post-industrial age requires new strategies to develop an adaptive society and maximize individual potential. Canadian policies are not clearly out of the industrial development stage. There is confusion.

Some provinces are more committed to 'welfare state' objectives than others, and see the need for social planning to attain these objectives, whilst the others are beginning to see social planning as a means to make better use of their resources and diminish wastefulness. As well, it is not always easy to

distinguish ends and means in developing social services for they may tackle social problems and at the same time provide employment.

A review of the federal, provincial and interest group reports shows an evolving conception of health care. The Hall Commission, 1964, produced a Health Charter and recommended that Canada take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all Canadian residents without hindrance of any kind. The Hall Commission was followed by the federal-provincial Conference of 1965 which agreed to the concept of federal-provincial cost-sharing for Medicare which was then introduced into all the provinces by 1970.

However, since the Hall Commission reported, the climate has changed and other federal committees have reviewed these problems: escalating costs proposed solution, more government involvement in planning; the better use of health manpower; the improvement of health care research, better information collection and dissemination; and priority setting for the better use of scarce resources.

Provincial governments have also been assessing their health needs and health resources and implementing programs. In Ontario it was said that broad objectives were easier to define than were the means to achieve them, particularly since it is clear that perceptions of need and demand for health care change according to changes in income, technology, tastes, expectations and social values. Priorities need to be socially determined and resources and structures properly organized. Better community health services need to be developed. Many suggestions for reorganization have been put forward and some of these are now being implemented by the Ontario government.

The Castonguay-Nepveu Report on health, social welfare and income security services in Quebec proposed a total reorganization of the health care system by legal enactment. The main principles to be applied to the reorganization were the determination of levels of care, the establishment of health centres, and regional organization of services into a three-tiered system of general, specialized and ultra-specialized care and the integrating of physical and mental health services. Solo practitioners and public health units were also to be brought into this total system of care. Health teams were to be promoted, and care in the

community was to be related to the natural environment. The public was to participate in a consultative capacity in local health centres and management of these centres was to be decentralized gradually by the sponsoring government.

Two special interest groups' reports are also significant for Canada. The Canadian Public Health Association after reviewing the state of public health services urged that governments should become involved in constructing health centres. The CELDIC Committee whose interest was in the million handicapped children in Canada emphasized the need for community involvement in identifying problems and giving help. This report stressed the need to distinguish between professionalism and professional competence and to get away from authoritarian and paternalistic attitudes on the part of those providing services.

All of these reports wanted more comprehensive services but all proposed different methods of providing them. Most agreed on trying regionalization, community health centres, new uses of manpower planning and research. Others mentioned developments in primary care, family practice and core curriculum for students preparing for the health professions.

REFERENCES

1. Liberal Party Pamphlet: Towards a Just Society, Ottawa, 1971.
2. Canada: Report of the Task Force on Costs of Health Care, Queen's Printer, Ottawa, 1969.
3. Klein, Rudolf: Resources, Priorities and Planning in the British N.H.S.
4. Trist, Eric: The Relation of Welfare and Development in the Transition to Post-Industrialism. The Canadian Centre for Community Studies, Ottawa, Mimeographed Nov. 1967.
5. Rein, Martin: Social Policy. Random House, New York, 1970.
6. Canada: Speech from the Throne, Queen's Printer, Ottawa, Sept. 1968.

7. Canada: Report of the Royal Commission on Health Services, Vols. 1 and 2, Queen's Printer, Ottawa, 1964.
8. Canada: Annual Review of the Economic Council of Canada (7th), Queen's Printer, Ottawa, 1969.
9. Canada: Department of National Health and Welfare, Reports
- &10. of the National Conference on Health Manpower, Ottawa, 1969, 1971.
- 11a. Canada: Department of National Health and Welfare: Assistance to the Physician. Ottawa, 1971.
- 11b. Canada: Department of National Health and Welfare: Report of the Committee on Nurse Practitioners: Ottawa, 1972.
12. Robertson, H. Rocke: Health Care in Canada - Progress Report and Commentary. Background papers for Health Sciences Committee of Science Council of Canada, unpublished, Ottawa, March, 1972.
13. Saskatchewan: Health Services Survey Commission, Report of the Commissioner, Regina, 1944.
14. Saskatchewan: Advisory Planning Committee on Medical Care, Regina, 1962.
15. B.C. Health Resources Council:
 - (a) Morgan, Robert: Technical Report S-1, Work Characteristics of Physicians of Fraser and Jersey, 1968, Dec. 1, 1969.
 - (b) Scarrow, H.: Technical Report M-1, Medical Manpower Survey 1968-69, Province of B.C., Oct. 31, 1969.
 - (c) Williamson, W.: Technical Report M-3, Nurse Manpower Study in the Province of B.C., June 30, 1970.

All mimeographed, available from the Department of Health Care and Epidemiology, University of British Columbia, Vancouver.

16. Cape Breton Regional Health Services: Kates, Peat, Marwick and Co., Halifax, N.S., Mimeographed, 1972. National Health Grant 603-21-8.

17. Manitoba, Cabinet Committee on Health Education and Social Policy, White Paper on Health Policy, Winnipeg. July 1972.
18. (a) Ontario Report of the Council of Health 1966-70, Queen's Printer, Toronto, 1970.
(b) Ontario Report of the Committee on the Healing Arts, 1966-70, Vol. I-III, Queen's Printer, Toronto, 1970.
19. Quebec, Report of the Castonguay-Nepveu Committee, Government of Quebec, Quebec. Vols. I-VI, 1970-71.
20. Canadian Public Health Association: Report of the Public Health Practices Committee. Toronto, April, 1971.
21. The (CELDIC) Report: The Commission on Emotional and Learning Disorders in Children: One Million Children. L. Crainford, Toronto, June, 1970.

IS THERE A NEED FOR ORGANIZATIONAL CHANGE?

CHANGING NEEDS?

Anderson et al ⁽¹⁾ made a survey of potential demand in the Kingston and surrounding rural area in 1970. They found that "the percentages of study subjects in all areas perceiving unmet health needs were relatively small. Most reported needs were for dental care, a problem which they described as due more to the high cost of such services than to the relative lack of services in the rural areas. This finding was in contrast to the prior expectations of the researchers that in an area of such poor access to health services, survey families would express considerable concern about inability to meet the perceived health needs. In fact, it appeared that families interviewed were generally prepared to travel as far as necessary to obtain the medical care that they required."

Their findings suggest that, at least in rural Ontario, minimum levels of demand for medical care have been met.

Anderson ⁽²⁾ suggests that the evidence on the demand for dental care coming not only from this study but also from the international (WHO/ICS/MCU) ⁽³⁾ study is of particular importance.

"It would seem that dentistry might well be in the state that medical care was in 25 years ago: one goes to a dentist because one has dental sickness in which pain is a predominant symptom. The situation is now confused in the case of medicine, perhaps because pain is only an infrequent symptom and because self-diagnosis is so commonly performed, it is very hard to rationalize the utilization of medical services on the basis of need and demand."

The question that arises is, if the public is satisfied with the outcomes of the care being given, need any steps be taken to inform them about the morbid conditions which are not recognized by them? Will Medicare bring Canada to a state of good enough health? This is not an easy question to answer.

The figures from the Canadian Sickness Survey 1950-51 ⁽⁴⁾ indicate that some redistribution of services was then very necessary (Table 9).

At that time, the lower-income groups had, in every age group, higher levels of disability.

TABLE 9

DISABILITY DAYS PER PERSON PER YEAR 1950-51

<u>Age Group</u>	<u>Low Income</u>	<u>Medium Income</u>	<u>High Income</u>	
			<u>Lower</u>	<u>Upper</u>
- 15.....	10.3	10.4	10.6	10.6
15 - 24.....	11.7	7.5	6.9	8.9
25 - 44.....	16.6	8.8	7.0	7.3
45 - 64.....	28.5	14.1	11.1	9.8
65 and over.	33.5	21.7	16.4	37.8*
All ages....	20.4	10.6	9.1	10.1

Source: Canadian Sickness Survey 1950-51⁽⁴⁾

*Estimate below Sickness Survey Standard of Accuracy.

Bell⁽⁵⁾ has also been analyzing the same sickness survey data in great detail. He found that the greatest amount of disabling illness and the greatest demand for doctors' services was to be found in the medium-sized towns. The highest number of doctors calls was for individuals in one of the two top income categories. The only exceptional area was Swift Current which had a comprehensive health service program. "Does this suggest that a break may be made between the general relationship of affluence and medical services measured in terms of doctors calls?" Possibly through Medicare and hospital insurance this break has begun to be made.

Access to some undefined minimal level of health care has come to be regarded as a right in the western countries. However, because of the unresolved issues about the extent of the minimum in the U.S., Rein⁽⁶⁾ examined the evidence about accessibility in the U.K. His conclusions about the importance of developing an organized systematic service were:

1. Contrary to the general impression that the middle-class make more use of the service because they are more articulate and better able to get access into the delivery system, the lowest social classes with the greatest needs make the greatest use of the physician and in-hospital medical care services and the care that they receive appears to be of as good a quality as that secured by other social classes. The availability of universal free-on-demand, comprehensive service appears to be a crucial factor in reducing class inequalities in the use of medical care services; other charges may have the effect of inhibiting use among the poor and unskilled.
2. Screening by general practitioners appears to contribute to equalization of class use.
3. The general practitioners tend to refer difficult problems upwards to specialists, not downwards or across to nurses and social workers. Thus hospitals are the receiving agents, not public health and social welfare departments.
4. The system is equitable. There may be a major conflict between equity and adequacy. "The challenge in the future is how to advance adequacy without sacrificing equity."

The plea made by Rein and others is for a one-standard system in which equal care is promised to all. At the present time this is not being provided in Canada (despite Armstrong's (7) argument that the Canadian system has always tried to be a one-standard system) because the system is still imperfectly organized.

A major conflict between equity and adequacy may exist, says Rein, and it is this conflict which is considered by Tsalikis (8) and Detwiller (9). How can the limited resources of the health services best be allocated?

Tsalikis has argued that the concept of free choice of physician is, for many people, largely a myth. He would like to see more government action and consumer involvement in the organization of health care to improve distribution of physicians' services. Detwiller is more concerned with abuse or overuse and wishes to deter those who make unnecessary demands on physicians.

Tonkin (10) suggests that the four areas of unmet need in British Columbia are rural and remote services, mental health and psychiatric services, dental health and community geriatric care.

It seems to be generally agreed that there is need for some reorganization of Canadian health services. It may be useful then to consider what new forms or organization have been advocated.

PROPOSALS FOR NEW FORMS OF ORGANIZATION: GROUP PRACTICE.

Some suggest that better value for money could be got simply by giving recognition to group practices. By paying the groups for services rendered rather than the individual physicians within the groups, a more flexible use of staff could be achieved. Smith⁽¹¹⁾ has argued that multi-specialty group practice should be encouraged. "Many well-organized private clinic groups and many groupings of doctors in medical office buildings provide a wide range of medical services just as well in non-university as in university centres. Out-patient diagnosis and treatment services available in many private organizations reduce the necessity for hospitalization, with a consequent saving in overall costs."

Although group practice has been mentioned in a previous chapter on existing services, it was stressed by the business managers of clinics that group practice is an innovative service without de jure recognition. Business managers of multi-specialty groups and community clinics had many common problems to solve. Despite some differences in viewpoint the business managers were committed to developing more efficient groups. Griffith⁽¹²⁾ elaborated on some of these difficulties. He said he did not think one could consider clinics as free-standing institutions. They had no legal entity, no income tax recognition, no pharmacy rights, no power against unions and university associations were minimal. They were often overlooked in planning for community needs, and hospital utilization was not properly linked to clinic practice.

Chase⁽¹³⁾, the manager of a multi-specialty professionally sponsored clinic, made some of the same points. Clinics are not recognized by organized medicine, universities or government. Fear of competition divides the medical community. Group practices have had to recognize the competition outside - thus equal partnerships are difficult to maintain (specialists object to equal division of income) and clinics in poorer provinces are always conscious of attractions elsewhere. As well there seem to be continuous political upsets affecting doctors' pay. It is

difficult to press doctors to give 24-hour coverage in these circumstances. Constantly the internal management of groups is affected by external pressures. Chase urged the necessity to negotiate with government for opportunities to develop a proper contractual service so that free competition might continue. A salaried service was not necessarily a good service. At the same time there was a need to work out new relationships with government so that group practices could better cope with union pressures, costs of staff training, location of buildings and costs of equipment, placement of branch offices and record linkage, so that there would be a rationalized service. Clinics should be expected to live within negotiated budgets.

In the business manager's seminar⁽¹⁴⁾ these points were made: Group practices are new forms of organization which have not settled down. They are struggling for identity and the different elements within them struggle for power to do their work well. The legal restrictions and funding mechanisms were developed for other purposes and need to be reconsidered, but the nature of a better system is still unclear.

At least these internal management difficulties can be identified:

1. Partnership is not very satisfactory. Incorporation is not likely to resolve all problems either, because it may be used as a tax gimmick and not as a basis for improving organization of services.
2. There is a distinction between making profit for the group, for the doctors and for businessmen sponsoring clinics.
3. Doctors do not understand that there are substantial profits in medicine, particularly relating to laboratories, drugs, etc. They tend to be inefficient entrepreneurs. Group practices which are not linked to laboratories, pharmacies, etc. do not make much profit.
4. Capital and operating costs should be separated. Doctors have problems in the capital financing of groups. Government capital financing may be a useful development, but there should also be opportunities for businessmen or voluntary groups to raise capital.

5. Multi-specialty groups are likely to lead to savings in hospital costs and better care outside hospitals (though hospital per diem rates may go up). Through the development of groups it may be possible to delegate work down to the lowest level of skill and thus save money because fee schedules could then be related to that level of service.
6. Group practice is likely to lead to innovation but this is presently held back by lack of government programs for meeting operating and capital costs in almost any new venture.
7. There is need for financial incentives to ensure productivity but some methods must also be found to prevent over-servicing and no one understands how to control demand at present. The articulate consumer gets a lot of service.
8. Business managers may be able to give leadership in the new power situation which is developing in group practices. Physicians have to be helped to work as a 'peer group', to learn to accept 'team work', to listen to consumers. Consumers are seeking to influence the characteristics of care, not to control it, despite doctors' fears. Consumer advisory boards may be useful but consumer control is not acceptable.
9. General practitioners do not make the most efficient use of the referral system because they are afraid of losing patients to other practices. Specialists are not being well used.
10. Group practices are better than medical arts complexes for effectiveness. Doctors and support staff communicate on matters of importance to patients if they are in the same organization. The great advantage of group practice is that it sees beyond individual goals to health care objectives while still providing satisfaction to individual practitioners. But group decisions should include patients' decisions, for their conception of health care needs differs from professionals.
11. Group practices appear to have higher costs relating to recruitment and training than do solo practices and medical arts groups.
12. The training of business managers is also a problem. Preferably they should be appointed at the time a group is formed. They need to have special skills, particularly in facility

planning and maintenance, management of income and investment, collective bargaining and staff management.

The following points were made about external relations:

1. Both government administrators and clinic managers have problems in dealing with changing Ministers and this is a time of great uncertainty for clinics. However, governments seem to be willing to discuss possible changes with the medical profession and other interest groups and to realize that changes have to come. Governments should try to facilitate evolution of new forms of practice. They should not control but develop guidelines for new facilities - decision-making should be decentralized as far as possible.
2. There is need to experiment with new systems of payment. This could lead to stabilization of costs, improved accessibility, more emphasis on preventive measures, better use of hospitals and reduction of acute care beds.
3. Even group practices cannot take on full-time all auxiliary staff that might give a good comprehensive service. The government should support any developments in practice that meet certain minimum standards. Consultants' services (e.g. psychologists') might be made available on a sessional basis. V.O.N. nurses might be attached. Well-baby care should be given in groups and not in separate health units.
4. Group practices might be wise to leave emergencies to the hospital. A combination of service by groups and hospitals should be worked out to suit the local community. There is wastefulness in reduplication. An ambulance service may be important and proper financial incentives to patients to use the most appropriate centre.
5. Governments do not have much experience in planning ambulatory care facilities. Knowledge lies in group practices.
6. But governments are not yet geared to thinking about group practice any more than fee schedules are developed to encourage grouping. Governments are not collecting the right data in order to be able to plan. Group practices do not know where to get answers to their questions when they have to approach government because so many separate departments deal with linked problems.

7. Government machinery will have to be changed. It was thought that communication is presently very inadequate and development of regional planning authorities or collective bargaining machinery will not necessarily deal with health care needs.
8. Possibly it might be necessary to lock in patients for a period to create enough stability in practices for good planning. Some concern was expressed about the passive people who are not at present making demands on health services and are not known to medical practitioners. The role of animateurs sociaux and indigenous workers in stirring up interest in these people was considered briefly. Were social activists political agitators, or did they represent people with real needs? It was pointed out that there have been difficulties in using indigenous workers because they lose touch with their own people very quickly.
9. It was thought that universities were failing to provide well-trained professionals for ambulatory care. As well they were a disruptive influence for established multi-specialty groups because they were liable to affect patient flow patterns.

Although it was to be expected that business managers would be concerned about financial problems, the weight of financial worries lay heavily upon them. Chase, particularly, brought to attention the problem of high-term high interest rates. The problem was raised on a number of other occasions (in the physicians' seminar⁽¹⁵⁾, in the design seminar⁽¹⁶⁾ and by Ruderman⁽¹⁷⁾). High interest rate costs are a heavy burden for many groups. Possibly there might be government subsidies for group practices if they were prepared to locate in an area where their services were badly needed. This form of help might also be useful to the innovative groups whose financial problems have been considerable.

It is clear that multi-specialty groups have, to some extent, become day-hospitals with high overhead operating expenses. Some groups are fortunate enough to do a lot of their work in the local hospitals and can, thereby, save on overheads but as a clinic gets larger or is located in a larger city, it gets more structured and institutionalized and cannot so easily gain access to the hidden subsidies.⁽¹⁸⁾ This raises questions about present methods of bringing in income. Have the physicians got accustomed to overservicing either in the urban clinics or rural

hospitals and if so should new financial or other incentives be devised to change their habits?

It was suggested that some patients have become accustomed to a high level of service, particularly if they are "the articulate middle class" and they too may have to be given incentives to behave in new ways.

It will be recalled that Ruderman's conclusion was that: "There is no proof that economies of scale exist, and a strong presumption that they do not", and that "Group practices tend to have higher costs of operation than equivalent fields in solo practice...costs associated with the use of more supporting personnel...more elaborate diagnostic equipment...and in some cases, shorter physician hours of work". The promotion of group practice, as such, was unlikely to achieve savings in the cost of out-patient treatment in such clinics. Thus, it might not be useful to promote this form of practice unless cost-saving behaviours could be developed. There would have to be changes in medical practice, either quantitative or qualitative, as well as "grouping" for increase of efficient and effective medical services.

Smith⁽¹¹⁾ says: "There is no difference between so-called consumer-sponsored community clinics and true multi-specialty groups insofar as cost reduction is concerned. There is marked increase in the turnover of doctors in the former, perhaps related to lower doctor satisfaction. The professional welcomes thoughtful and useful advice from the consumers of medical care... (but not when) consumer involvement (is) through boards appointed by and responsible to the government of the day."

He goes on to say that priorities in health care demands must be established. Many social problems lie outside the purview of the medical profession and a lot of time is wasted in dealing with unnecessary examinations and screening procedures. He believes that the present system of remuneration is best and whilst physicians can exert some control through peer reviews, governments are also responsible for restricting demand. He suggests that good use should be made of allied health professionals and social workers but they should not be overused. Increase in the number of minimal care nursing home beds and a better home care service would reduce hospital occupancy and lead to better care, particularly for the aged.

HEALTH MAINTENANCE ORGANIZATIONS

An extension of the group practice model is known as 'pre-paid group practice' in the United States. The advantage of the United States model is that primary, secondary and tertiary care are linked into one system by incentive payments to clinics or physicians.

Greenlick (19) of Kaiser Permanente claims:

"Group medical practice has been shown to reduce hospitalization rates and to diminish markedly what can be viewed as unnecessary surgery. Judging from the high proportion of eligible members who receive some form of care each year, accessibility seems to be improved. The use of appropriate preventive services by members seems higher than in other types of medical care arrangements. To some extent this system appears to minimize the duplication of effort, personnel and facilities that characterizes the individual fee-for-service system. In terms of overall cost savings and the ability to provide high quality care with patient satisfaction, prepaid group practice seems to offer major advantages over other systems... Various features of this health care alternative are shown to offer potential for control of quality and efficiency."

Mott (20) suggests that it is in this model that "overwhelming evidence" may be found "that the operation of a good prepaid group practice plan can change the whole balance of services towards the ambulatory side, with marked reduction in hospital use. Many major plans besides Kaiser have shown this. There is less, but still strong evidence, as to the greater cost effectiveness of these plans, in general demonstrating more comprehensive services for the same money."

The U.S. Government has recently proposed that Health Maintenance Organizations (HMO) might be a means to the improvement of the health status of the American people.

Pearson (21) has described the proposal in which four basic ingredients must be present:

1. An organized health care delivery system which includes the health manpower and facilities capable of providing, or at least arranging for, all the health services a population might require.

2. An enrolled population, consisting of individual persons and groups who contract with the delivery system to receive a range of health services which the system assumes responsibility to make available.
3. A financial plan which negotiates prepayment by individuals and families and thereby collects the money needed to cover the costs of the agreed upon set of services.
4. A managing organization which assumes legal, fiscal, public and professional accountability.

"A number of active health care delivery systems in the U.S. are considered as models for HMO. Their characteristics vary quite markedly between prepaid group practices, such as Kaiser Permanente and the Health Insurance Plan of Greater New York and prepaid solo practice such as the Physicians' Association of Clackamas County and the San Joaquin Foundation for Medical Care. (22)

"There is tremendous interest and a surprising degree of enthusiasm for HMO from both providers and consumers of health care. The concept is sufficiently broad for different interpretations to be made, and different virtues found. The Congress has already included an HMO option in its Medicare legislation. Organized labour has given the strategy its official endorsement, as a valuable step towards national health insurance and as part of a national health plan. Local medical societies and other groups of physicians are making plans to develop into medical foundations. Medical schools are interested, and some already have operational HMO and others are planning ones. Neighbourhood health centres are taking steps to convert to HMO. Hospitals are exploring converting their out-patient operations into HMO. Blue Cross Associations are negotiating with prepaid group practice plans. Insurance companies and industrial corporations are exploring the feasibility of HMO, in some cases for their employees and in other cases as an investment. Fifty-two grants and contracts have already been let out across the U.S.A. to sponsors from most of these groups.

"The HMO concept appears to offer the hope that:

- . The rising costs of health care can be contained, because the incentive of health care workers will be to hold back costs since they have committed themselves to work within a budget, and stand to benefit, either directly or indirectly from money not spent.

2. The maldistribution of health manpower can be contained and perhaps reversed. This is because there will develop a limit to the number of physicians a well-to-do area can support, as well as the potential for profit from practice in poor areas which presently offer rather small financial rewards to a physician.
3. Hospitalization rates will go down, as documented in the pre-paid group practices.
4. Health care will become more accessible.
5. Health care will be organized more efficiently.
6. Quality of care will be improved.
7. Continuity of care will be enhanced.
8. Health manpower will be used more judiciously.
9. Physicians may become oriented towards keeping their patients well, or at least preventing disability, as reciprocal relationships are strengthened by the enrolment process.
10. There will be local autonomy, in the American tradition, in the way HMO develop; they can be designed creatively at the local level within the financial constraints."

Pearson says there are three major problems with the present concept of HMOs for the U.S.A.:

1. The inclusion of care for poverty groups in the design.
2. The magnitude of the financial undertaking.
3. The continued fragmentation of health care.

In addition there are some problems with U.S. laws and customs.

He believes that HMOs have some advantages which Canada should consider:

- (a) cost containment which appears to be a priority for the HMO, "puts the doctor in the position of deciding if and how money will be spent for the patient for medical care. There are positive incentives to economize,

- (b) flexibility in local arrangements which should avoid professional antagonism,
- (c) the bringing together of ambulatory and hospital services, preventive and emergency services into one organizational model,
- (d) the potential for bringing physicians to work together with other health workers,
- (e) the concept of enrolment (or lock-in) which creates a partnership between doctor and patient and makes possible preventive screening and surveillance.

CANADIAN COMMUNITY CLINICS

The clinics in Canada which have some affiliations with the Group Health Association of America; the Sault Ste. Marie and St. Catharines clinics and the Community Clinics in Saskatchewan; have claimed that they are more effective in keeping their patients out of hospital than other group practices despite funding arrangements, as they presently exist, creating difficulties for them.

The unions sponsored the two clinics in Ontario (St. Catharines and Sault Ste. Marie) and the C.C.F./N.A.P. in Saskatchewan sponsored 35 clinics. Group Health Associations were formed in 1962 in 35 communities in Saskatchewan although only 14 clinics were started and only nine survive today.⁽²³⁾ Many of the associations were quite unrealistic in their plans to attract physicians to small prairie towns, and others which did so failed to keep them. There were many reasons for this not unlike the reasons Szasz⁽¹⁰⁾ gives for the rise and falling off of interest in student-sponsored clinics - the personalities of the physicians who became involved, the strong action-orientation, and the problems of organizing the clinics on a sound financial basis. Above all, however, unlike the reaction to the student clinics, there was a strong and militant professional opposition. The clinics felt they were harassed by the rest of the medical profession. And because of the political alignments of their sponsors they also became involved in the political quarrels between the Liberal party and New Democratic party.

Hastings et al (24) and Vadya and Kopplin (25) have made detailed studies of the Sault Clinic. They conclude that hospitals are less used by the physicians practicing in these clinics which were funded on a capitation basis.

Anderson and Crichton (26) compared three urban Saskatchewan community clinics with 14 other group practices and two 'groups' of solo practitioners. The community clinics were funded in exactly the same way as the other clinics in the province, namely from the fee-for-service system administered by the Medical Care Insurance Commission. These clinics also used hospitals less when they were compared with other clinic groups within the same geographic region. It was noted, however, that the greater reduction in hospital use was associated, not with surgery, but with medical services. It was suggested by the authors that the community clinics and other large multi-specialty clinics, which provided large volumes of out-patient diagnostic services, may in fact have transferred the medical investigation from the hospital to the group practice or health centre. Of considerable interest was the fact that these economies were found without special forms of home care programs. It thus became clear that these community clinics may be providing a unique and different kind of service, but they have not yet been able to develop this to its full potential because funding mechanisms have prevented them from expanding the non-physician medical services to the extent which they would have liked.

However, some economies may exist simply because the clinics were operating in urban centres where there is a relative shortage of beds compared with rural centres. One of the clinics, located in a city where more beds were available, showed a much higher rate of hospitalization than the other two. It will be recalled that some physicians had difficulties obtaining hospital privileges, so the clinics may have become inventive about other methods of treating patients.

While some of the physicians were strongly committed to the New Democratic Party many were not anxious to have any involvement with party politics.

The community clinic physicians, who had pushed hard to have the Anderson/Crichton (25) study funded, repeatedly said that they were anxious to show that they had a better quality of professional practice than other clinics rather than to demonstrate more concern for the poor, although they were also interested in poor people.

It would appear that the community clinic physicians had not found it very easy to work with their Boards although they were continuing to explore ways of doing so, particularly in Saskatoon and, after an interval of reduced communication, in Regina. They seemed to be much more concerned to stand well with the medical profession. And, since they were at loggerheads with the local medical profession, they appealed to a cosmopolitan audience of physicians and other experts in health care organization who could be expected to understand what they were trying to do.

SYSTEMS LINKAGE

Matthews, (28) who was at one time Medical Officer for the Swift Current Regional District, does not think that it will be enough just to reorganize the delivery system for primary care alone into group practices or community health centres. It must be provided within a linked system of primary, secondary and tertiary care, otherwise repetitive and unnecessary work will be done.

He reviews the municipal doctor plans of Saskatchewan and suggests that these were the origins of the community health centre concept. The members of the Municipal Council formed the Board of Directors of the municipal plan which was supported by municipal (and later provincial equalization) taxes. In general, the physician who was paid a salary was encouraged to carry out preventive and curative services. The main problem for citizens was lack of freedom of choice of doctor; the physicians had little professional support since only the larger plans were able to employ nurses, laboratory and x-ray technicians. Some plans allowed the physicians to make additional charges for surgery, obstetrics, anaesthesia and mileage, and some provided an office and a home. But there were a number of changes which led to the plans being folded up.

Matthews recalls that a number of model health centres were built in Saskatchewan after 1952 following the Sigerist Report (29) which had proposed that rural Saskatchewan should be served by a series of health centres serving local communities - a physician's office, diagnostic services, space for a public health nurse, public health inspector and in some areas an office for a dentist, and that these health centres should provide ambulatory care to the public with a limited supplement of hospital

services. The health centres in time became known as rural hospitals. The emphasis was on treatment services provided to in-patients; very few supplementary services were developed and the health centre concept has made very little progress in the past 25 years. Matthews lists what he believes to be the main reasons for failure of the concept.

- "1. The health centre was organized, financed and under the direction of a Union Hospital Board that considered in-patient services to be their primary responsibility.
2. The health centre was promoted on the concept of a "medical model", designed to provide more efficient delivery of physicians' services, using other professional staff as supplementary to the physician.
3. In-patient hospital services were insured on a comprehensive basis through a provincial plan. Therefore, they were available to the patient at no direct cost.
4. Comprehensive physician services both in-patient and out-patient were available through a regional insurance program financed by a regional organization separate from the hospital insurance program.
5. There was no insurance coverage for the services of supplementary personnel to provide ambulatory services outside of the hospital setting, such as home care, home nursing, physiotherapy, medical social services and drug benefits for ambulatory patients.
6. Dental services were limited to children up to twelve years of age.
7. The public health services were separately organized and separately paid for and were regarded as renters within the health centre.
8. The physician as a private fee-for-service practitioner rented his offices from the health centre.
9. The model health centre as recommended by the Provincial Health Department which was built in a number of areas, placed physician services and in-patient hospital services on the main floor and all other services in the basement. This may

have been an indication of the views of the Health Department with respect to priorities.

10. The major aim of the Health Department was to promote and develop universal hospital and medical care insurance.

Matthews continues: "It is my opinion that community health centres will not have any fundamental influence on the nature of the health services program unless they include in their concept and design certain basic principles:

1. The sponsoring body should preferably be a public body of some kind.
2. If under some circumstances it is not a public body, then it should be a non-profit organization and in both cases should reflect substantial consumer participation in the sponsoring body.
3. The health centre should assume the responsibility for a comprehensive scope of personal health services to the population they are designed to serve. If a single health centre is unable to provide a comprehensive range of services, then it should make arrangements for additional health services through other health centres, hospitals and other agencies.
4. The range of services provided by health centres should include health promotion and preventive services; diagnostic services, medical care, both emergency, acute and long term; and rehabilitation.
5. In order to provide this comprehensive range of services, the health centre must either employ or have access to a wide range of professional services in the fields of medicine, nursing, dentistry, rehabilitation, vision care, nutrition, and medical social services.
6. Coverage should be available and designed to serve the total population of a defined area. Although the health centre should be designed to meet the special needs of particular groups or particular areas, it should not be used as a mechanism for dividing the health services between classes of people.
7. The health centre should be organized in such a way as to promote a group practice approach to the health problems of

the community it serves. The group should be multidisciplinary in nature with nurses, dentists, physicians as part of the therapeutic team.

8. The financing of the health centre should be such that the health centre will receive, in advance, payments estimated to cover the cost of a comprehensive range of services. The amount paid to the health centre should be related to the number of persons it serves or the number of families, plus the range of services. Optional methods of payment to professional staff, a salary system of payment is favoured."

If health centres are to succeed, says Matthews, the following are the prerequisites:

- "1. A regional Board of Health with power to coordinate services
2. Clear definitions of powers and authorities of health centre boards.
3. Public representation on these boards.
4. A proper legal basis on which health centre organization is promoted. Voluntary organization will not be enough.
5. Defined relations between health centre boards and regional authorities.
6. A master plan for all health agencies and institutions including private practice is now well established.
7. A computer information system.
8. Public education.
9. Adequate discussion with professionals and development of contractual arrangements."

To recapitulate, Roemer⁽³⁰⁾ has examined the development of health centres throughout the world. He says that they are a reaction to specialization in medicine and medical care programs and have similar characteristics everywhere: they emphasize early diagnosis or preventive care, primary health care, family counselling and therapy and the avoidance of hospitalization. But the health centres need to be backed up by hospitals and so the

outcome is regionalization - a call for systematized planning, collective financing, and "removal of the health service increasingly from the entrepreneurial market and establishing it as a social service available equitably to all in relation to need".

The development of a regionalized system of care is important for the distant centres of population. In Russia, feldshers are used to man the Siberian health units and can do so effectively when they are backed by a system of further education and consultancy.(31)

SOCIAL DEVELOPMENT IN QUEBEC

It is in Quebec, particularly, that the idea of the development of health centres has been closely linked to improvement in general social welfare and Quebec appears to have been strongly influenced by American ideas about opportunity programs for minority groups.(32)

HEALTH SERVICES ORGANIZATION IN QUEBEC

A schematic outline of the Organization of Health Services as recommended by the Castonguay-Nepveu Health and Social Welfare Commission(33) follows:

"I. Goals

1. General Goals

- (a) improvement of the state of health of the population
- (b) improvement of the state of the environment

2. Specific

- (a) universal access
- (b) regime acceptable to the population

- (c) quality care services from the scientific, human and social point of view
- (d) effectiveness

II. Health Services Organization

1. Fundamental characteristics of the regime:

- (a) global medicine
- (b) open system: utilizing all the resources of the milieu to produce
- (c) responsive to change

2. Guiding principles for the organization of the regime:

- (a) determination of the three levels of care:
 - general care
 - specialized care
 - supra-specialized care
- (b) establishment of three categories of health centres
 - the L.H.C. (Local Health Centre) or C.L.S. (Centre Local de Santé)
 - the C.H.C. (Community Health Centre) or C.C.S. (Centre Communautaire de Santé)
 - the U.H.C. (University Health Centre) or C.H.U. (Centre Hospitalier Universitaire)
- (c) regionalization of health services based on three criteria:
 - minimal population base of 600,000 inhabitant
 - presence of at least one U.H.C.
 - autonomy in the production of health services
- (d) based on these criteria, the Commission concludes that there need to be at least three health regions in Quebec.

3. The Local Health Centres: (C.L.S. - Centres Locaux de Santé)

- (a) meet the needs of a population of 10,000 to 15,000 inhabitants
- (b) offer general services, ambulatory and first line services
- (c) are composed of a team of doctors, nurses and social workers
- (d) are accessible within a 30-minute drive or less
- (e) provide integrated and complete services
- (f) are responsible for the health of entire population of their respective area and the continuity of the services.

4. The Community Health Centres: (C.C.S. - Centres Communautaires de Santé)

- (a) meet the needs of a population of 100,000 to 150,000 inhabitants;
- (b) offer complete specialized services;
- (c) are accessible within 60 minutes or less;
- (d) are organized according to progressive or graduated care;
 - intensive care,
 - continued care,
 - current care,
 - long term care,
 - home care,
 - out patient care;
- (e) have a minimal size of 300 beds, but in general should average 400 to 500 beds.

5. The University Health Centres:

- (a) offer superspecialized services;
- (b) are the centres of research and teaching.

6. The Regional Health Offices:

- (a) are to be three in number at first:
 - Sherbrooke (840,000 inhabitants)
 - Quebec (1,560,000 inhabitants)
 - Montreal (3,473,000 inhabitants)
- (b) organs for the control and financing of regional systems and institutions;
- (c) are in some sort regional mini-ministries;
- (d) utilize a participation model.

7. The Norms:

- (a) hospital beds per 1,000 inhabitants:
 - 3.2 for the acutely sick (2.9 in the C.H.C. - 0.3 in the U.H.C.);
 - 1.5 for the chronically sick and convalescents
 - 0.5 for the chronic psychiatric patients;
- (b) the Commission suggests that the diminution of beds be compensated by the development of:
 - home care services;
 - out-patient services;
 - preventive care services;

integrated in the health services distribution system

8. Doctors:

- (a) integrated in the institutions of the regime;
- (b) work in teams with other health workers;
- (c) remuneration by salary.

A model for community health centres; proposed by Alix⁽³⁴⁾, a social planner in Quebec, is much more complex than that of Matthews.

Not only does he define the basic principles on which community health centres should be established, he describes the process of adaptation which they would have to undergo in order:

- (a) to provide, in a dynamic way, the necessary services for the population of the district, which should itself be changed by the introduction of the centre;
- (b) to develop "teamwork" for, as he says, there should be changes in the interrelationship of the staffs of centres as new patterns of practice develop in order to meet changing community needs.

Alix began his paper by quoting the legal definition in Quebec's Bill 65⁽³⁵⁾: "un établissement qui, sur une base locale, assure à la communauté des services d'action sanitaire et sociale, reçoit les personnes qui requièrent pour elles ou leurs familles des services de santé ou des services sociaux courants, les conseille ou les dirige vers les autres institutions les plus aptes à leur venir en aide et, si nécessaire, leur prodigue les services de santé ou les services sociaux courants." It is necessary, says Alix, to make this theoretical definition operational before going on to specify what would be the necessary resources for developing centres. Thus his operational definition is "une unité de distribution des services dispensés par une équipe multi-disciplinaire de professionnels". He proposes the development of a manpower matrix in order to provide teams for manning programs to be undertaken by a health centre.

CHART 11

PROGRAMMES POSSIBLES D'UN CENTRE LOCAL DE SANTE

<u>Programmes</u>	<u>Main-d'oeuvre</u>	<u>Equipement</u>
<u>A - Éducation (Education)</u>		
<u>B - Dépistage (Case-finding)</u>		
<u>C - Prévention (Prevention)</u>		
<u>D - Diagnostic (Diagnosis)</u>		
<u>E - Traitement (Treatment)</u>		
<u>F - Réadaptation (Rehabilitation)</u>		

Of course, he says, there could be subspecialization within each of these general areas, e.g. specific programs of health education for schools, workers, etc.

He believes it is necessary to develop a breakdown of this kind because different teams are required for different services - a team of district nurses might serve 2000 people, while a chest x-ray team might serve 5000. Thus no centre would be like any other but would be planned specifically to meet the particular needs of the local population. But because it would not be possible for all centres to provide all kinds of services, the centres would have to be linked into a system and services might be transferable from one centre to another if the need shifted geographically. Or else, a team which was not much needed in one district might have its main office in another town where the principal demand for its services was clearly demonstrated but could provide service to the other district to meet its demand on a travelling basis.

Whether or not specialist teams should work at the primary or secondary level will depend on local circumstances. For example an asbestos mining town may need to have its own chest x-ray service at the C.L.S.C. (This would normally be regarded as a specialist service in any other circumstance to be provided at secondary levels of care.) So there may have to be adaptations in planning to make sure that specialist services are placed where required.

Because the centres have to be responsive to local needs it is important that communication networks be good. The staff in the centres must be aware not only of the local milieu but also be able to communicate well with the health service system generally about these needs and how to resolve them.

In order to discover what are the local needs there must be liaison with other institutions - schools, the welfare department, etc. It is important, then, to try to ensure that regional districts are the same for all services - health, education, welfare, municipal government.

The idea is to develop a possessive feeling among the inhabitants about their locality, so 'grey zones' must be ended if participation and decision-making are to be developed on a sound basis. The emphasis is on community and slow growth of services to meet community demand.

As mentioned before, Alix sees that this emphasis on community will challenge the power of professionals as it now

exists. They will be expected to hand over some of their power to semi-professionals and consumers. He describes this as "une multi-disciplinarité humanisée puisque l'objet même du système est l'homme".

He does not think the development of community health centres will be rapid because there will be resistances. Voluntary demonstration models will be necessary for a long slow apprenticeship of physicians and other professionals to the new approach. "Is the first stage the reallocation of power within the team?", he asks. There should be a more equal distribution of rewards (the method of payment is not significant but equality is). He thinks it will take a long time for members of a team to be able to look at problems in the way that other members do, therefore he would keep teams small: "The more in a team, the more problems, the more likelihood of conflict."

It is important, he believes, to evaluate continuously and make adjustments.

Discussing the place of health centres in the total system, he points out that the Castonguay Report visualizes both a public and a private system working alongside one another but the public centres will be controlled by autonomous local communities. This will create problems of interdependence and he foresees problems of professional inflexibility unless structural solutions are provided to develop "complementary roles".

It is easier, he admits, to plan for rural than for urban areas where services are already well established on an entrepreneurial basis and where there is more stability in population and demands for service. He suggests that there may be difficulty in urban areas when established conservative medical professionals are challenged when professional power is to be replaced by bureaucratic power. "The strategy of the change", he says, "is as important as the change itself".

COMMUNITY CARE

In Quebec, the Ministries of Health and Welfare are combined into one Ministry of Social Affairs. Thus it is proposed that the local and community health centres will be centres for information about social services, referral agencies for those who need appropriate professional help and sources of community action.

The relationship between the health and social services at the local level has still to be worked out. What is to be the appropriate funding of health and social services and how will this be determined?

Canadian governments may feel that in promising to meet medical care needs they were opening Pandora's box, but much more has still to be done as they move further into "community care" as the British call it. In Canada the usual expression is ambulatory care but that does not really convey the idea that Canadians have reached a new stage of thinking.

"Is it appropriate to recommend the transfer of investigative services from the hospital to the ambulatory clinics without providing a national form of sickness insurance or compensation to pay for the increased personal costs involved?" asks Anderson (C). In other words, to make this transfer without developing a new form of social insurance could, in fact, make the community health centre more the model health care delivery system for the middle-class and further alienate the poor. Does this mean then that 'free clinics' may have to go into homemaking and baby-sitting services? I really think so. The economic burden to the lower-class family of caring for the sick and disabled at home and the competition with its wage-earning capacity when it is asked to provide care is, to me, socially reprehensible. I feel that health centre development may in fact serve to impede the equitable distribution of resources."

Great Britain has been committed to the idea of developing "community care" since the Mental Health Act, 1969 and the Community Care Plans, 1963, were introduced. But the concept of a 'welfare state' had been developing for many years before this.

The first reaction was to develop more courses for the training of professional social workers and to reorganize their work and responsibilities. Later, attention was given to training and deployment of volunteers. Now, questions are beginning to be asked about the families who have to bear special burdens of chronically sick or disabled members in a society supposedly concerned about equality of opportunity. Some modifications in legislation relating to sickness insurance and payments to the long-term disabled have been made in recent years, but there is no doubt that families with sick, disordered and disabled members are penalized. Many recent articles explore the shortage of social workers⁽³⁷⁾ or "the desperate shortage of suitable accommodation for various categories of people, and the ways in which

social workers surmount difficulties for their clients by indirect action and attempt to keep a proper choice open for their clients all the time"(38). Others(39) discuss the problems of getting families to cope: "Some idealists believe that substantial numbers (of retarded children) will be able to go back to their homes in the near future and that others, particularly children, may be fostered or adopted. Unfortunately, there is no evidence whatever to support these views. Parents with mentally subnormal children at home frequently get minimum or no support from the welfare services. Friends and neighbours are often unsympathetic and many mothers become completely housebound and socially isolated. Often it is impossible to find anyone willing to look after the child even for short periods."

Geriatric needs and facilities are known to be inadequate. Medical problems have been much easier to solve than social problems and many studies have shown that hospital beds taken up by old people are filled by those in need of nursing, not medical care(40). They are often single old people - unmarried or widowed without support in the home(41).

"There is a certain ambiguity in casting a health care system in the role of an instrument for securing social justice. There is, of course, a distributional aspect in the delivery of medical care itself: Do all people have equal access? But a health care system is more than a machine for delivering purely medical facilities...This dual aspect of the problems facing a health care system, the intermingling of social with medical morbidity needs (renewed) stressing today... For, given the increasing costs of providing medical services, it is now more than ever questionable whether a health care system is the right instrument for dealing with social problems... To the extent that a health service is asked to play a more general socially supportive function, it is being cast for a role where the medical profession's traditions are a major obstacle and where the skills involved can often be supplied at lower cost by others. If this view is correct, then the main objective for the future should be to contain rather than expand expenditure on the health services as such, but to integrate them more closely with, and divert any extra resources to, the socially supportive services"(42).

SUMMARY

A study in Eastern Ontario found that patients were satisfied with a relatively unsophisticated medical care service. They wanted more access to dental care. Is public demand related to pain? If so, medical care is at a different stage from dentistry, and public need and public demand have become very confused issues.

In 1951, a Canadian Sickness Survey indicated that lower socioeconomic income groups had higher levels of disability and that the highest demand for medical services came from the top two income groups. Where there was a comprehensive medical service in Swift Current the pattern was different. Possibly the introduction of medical care and hospital insurance have changed the 1951 patterns of demand but we do not know because there is no recent survey evidence.

There appears to be need for some change in administrative organization of services. Rein examined the U.K. evidence and it showed that free access to health care led to greater use by lower socioeconomic groups. Screening by general practitioners assisted equitable distribution but led to many referrals to specialists. Rein thought there might be a conflict between equity and adequacy.

Group practice is suggested as one improved form of organization. Presently it has no legal recognition. Community clinics and multi-specialty groups share many problems of uncertainty in management. Many power struggles exist within groups and between groups and other institutions in the community. The business managers identified a number of these internal and external problems.

Capital costs are one special problem, as are operational costs of multi-specialty groups and day hospitals with high overheads. They do not get hospital subsidies.

Multi-specialty groups were said to offer an alternative service to community health centres. They appear to be better able to retain physicians. But physicians will not welcome consumer control through Boards responsible to government.

Possibly much of the work of multi-specialty groups should be done elsewhere by social workers and others. Improved nursing home and home care services could take a lot of weight off physicians.

Health Maintenance Organizations are being developed in the U.S. on the Kaiser Permanente model. It is claimed that this form of organization minimizes duplication of effort, personnel and facilities and changes the balance towards ambulatory care. There is some evidence of greater cost effectiveness. HMOs are characterized by an organized delivery system, an enrolled population, a financial plan and a managing organization. HMOs may be sponsored by physicians, consumers or others. The main advantages are cost containment, flexibility of local arrangements, the bringing together of ambulatory, hospital, preventive and emergency services into one model; the potentiality for getting physicians to work with other health workers; and the concept of enrolment with greater potential for prevention.

Doctors in Canadian community clinics claim that they make less use of hospitals than other physicians and to some extent these claims have been substantiated. They may have developed a unique kind of service which has not reached its full potential because of funding difficulties. New roles for allied health professionals have been tried out in these clinics, particularly using social workers and members' relations officers. Many group health associations that were formed to sponsor community clinics have not been successful in getting clinics going or maintaining them. There has been great hostility from the medical profession. The group health associations became involved in political quarrels.

The physicians of these clinics were anxious to stand well with the medical profession - internationally if not locally. They seem to have emphasized this more than their concern for lower socioeconomic groups.

An attempt to develop health centres in Saskatchewan following the 1944 Sigerist Report may have come too soon. When federal monies became available for hospital construction, the health centres became rural hospitals. In some cases public health workers were located in the same building. This experience provides some guidelines for future development of community health centres. Matthews says if they are to succeed they will have to be part of a total system with public or non-profit sponsorship. Regionalization will be particularly important for remote areas.

In Quebec the development of community health centres has been closely linked to improvement in general social welfare, community and individual development. A model for community health centres describes the processes of adaptation:

- (a) to provide in a dynamic way the necessary services for the population of the district which should itself be changed by the introduction of the centre;
- (b) to develop team work for there should be changes in the interrelationships of the staff of centres as new patterns of practice develop in order to meet changing community needs.

The development of modular teams would enable community health centres to meet needs as they arose and to adapt to changing needs. The emphasis on community involvement would mean that teams would have to be prepared to share their power as the community members developed into full participants. The development of community health centres will be slow. Resistances will be strong. Teams will not be easy to develop. It will be easier to start in rural areas where there are presently few services. At the beginning the new system will have to co-exist with the old. The strategy of change is as important as the change itself.

In Quebec, community health centres are to be centres of social information as well as medical care centres, but this may be easier to achieve in Quebec than in other provinces, for in Quebec health and welfare services are the responsibility of one Minister. Yet it seems unlikely that 'community care' can be developed much further without this linkage. If patients are to be treated on an out-patient basis instead of being hospitalized they and their families will have to bear higher costs. The development of community health centres without social support services would put a greater burden on the poor than on the middle classes.

The development of community care in Britain has not been untroubled. The emptying of chronic care institutions for retarded children, geriatrics, mentally ill, etc. put burdens on the family because neighbours are not usually willing to give long-term, and sometimes even short-term, support. It may be necessary to reconsider reallocation of resources between health and social services. Health care may be better provided by professionals other than the medical profession.

REFERENCES

1. Anderson, R.W. et al.: The Role of a Medical Faculty in Reorganizing Family Practice to meet Current Community Needs. Canadian Medical Assoc. J., 103, Sept. 26, 1970.
2. Anderson, D.O.: Personal communication.
3. White, Kerr L. et al.: Ecologic Results in International Comparisons of Medical Care. Milbank Memorial Review Quarterly, Vol. I, No. 3, Part 2, July, 1972, pp. 31-44.
4. Canadian Sickness Survey 1950-51. Queen's Printer, Ottawa, 1960.
5. Bell, Norman, W.: The Canadian Family Illness Project. Vol. I, Department of Sociology, University of Toronto, 1969.
6. Rein, Martin: Social Class and the Health Service. American Hosp. Assoc. Vol. 43, No. 13, 1969.
7. Armstrong, R.A.: Some Observations on Methods of Physicians' Remuneration in Canada.
8. Tsalikis, George: The Patient's Freedom of Choice and the Community Health Centres.
9. Detwiler, Lloyd: The Canadian Health Scene. Political Reality.
10. Tonkin, R. and Szasz, G.: Two Views of Community Health Centres.
11. Smith, N.H.: Ambulatory Health Care - The Views of a Clinic Physician.
12. Griffith, F.E.: Problems of an Administrator.
13. Chase, M.I.: Some Administrative Problems and Experiences of a Business Manager in a Regional Multi-Specialty Clinic. Part I - External Affairs, Part II - Internal Affairs.
14. Crichton, Anne: Summary: Seminar, Business Management.

15. Greenhill, Stanley: Summary: Physicians' Seminar.
16. Ogrodnik, T.M.: Summary: Design Seminar.
17. Ruderman, Peter: Economic Characteristics of Community Health Centres - Summary and Conclusions.
18. Evans, R.G.: (a) The Impact of Health Centres on Patterns of Hospital Expenditure.
(b) Community Health Centres and the Cost of Acute Hospitalization in Canada.
19. Greenlick, Merwyn R.: (a) The Impact of Prepaid Group Practice on American Medical Care: A Critical Evaluation. Kaiser Foundation. Portland, 1971.
(b) A more detailed description of the Kaiser-Permanente program is given in Saward E.W.: The Relevance of Prepaid Group Practice to the Effective Delivery of Health Services. Office of Group Practice Development, U.S. Department of Health Education and Welfare, Washington D.C., 1969.
20. Mott, Frederick D.: Personal communication.
21. Pearson, R.J.C.: Health Maintenance Organizations.
22. Proceedings, Conference on HMO, American Hospital Association 1970. Hospitals, March 16, 1971.
23. Community Health Cooperative Federation, Saskatoon. Personal communication to M. Warner who prepared the case study of the Saskatchewan Community Clinics. 1971.
- 24a. Hastings, J.E.F., Mott, F.D., Hewitt, D. and Barclay, A.: An Interim Report on the Sault Ste. Marie study: A Comparison of Personal Health Services Utilization. Can. J. Public Health, Vol. 61, 1970, p. 289-296.

- 24b. Hastings, J.E.F. et al.: Prepaid Group Practice in Sault Ste. Marie, Ontario. Unpublished paper, School of Hygiene, University of Toronto, 1972.
25. Vayda, Eugene and Kopplin, Peter: Internists in a Canadian Prepaid Group Practice Program. Unpublished report, McMaster University, Hamilton, 1971.
26. Anderson, D.O. and Crichton, A.: Economies of Group Practice, in Saskatchewan. Unpublished manuscript, University of B.C. 1972.
27. (a) Ghan, L. and Road, D.A.: Social Work in a Mixed Group Medical Practice. Canada, J. Public Health, Vol. 61, Nov.-Dec. 1970. p. 488-496.
(b) Mossing, Jeanette M.: Nursing Case Work: The Canadian Nurse. June 1966, p. 54-55.
(c) Wolfe, S. and Teed, G.: A Study of the Work of a Medical Social Worker in a Group Medical Practice. Can. Med. Assoc. J., May 27, 1967, p. 1407-1416.
(d) Ghan, Len and Road, David: Doctors, Patients and a Psychotherapist: An Analysis of Interaction, 1966-1968. Unpublished report, Medical Group of the Regina Community Health Clinic, 1968.
(e) Ghan, L. and Road, D.: Relationships Among the Health Team: A Group Practice Report its Findings. Canad. Fam. Physician. Nov. 1971. p. 55-57.
(f) Ghan, Len: Social Work Practice in Community Health Centres.
28. Matthews, V.L.: Community Health Centres; Comments on Organization.
29. Saskatchewan: Health Services Survey Commission, Report of the Commissioner, Regina, 1944.
30. Roemer, M.I.: Organized Ambulatory Health Services in International Perspective. Internat. J. Hlth. Services, Vol. I, No. 1, pp. 18-27, 1971.
31. Wallace, J.D., General Secretary, C.M.A.: General Impressions--Trip to U.S.S.R. Unpublished Report, June/July, 1971.
32. (a) See references to Chapter 3 and
(b) Kohn, Robert and Radius, Susan: The United States' Experience.

33. Quebec: Report of the Castonguay-Nepveu Committee, Quebec. Government of Quebec, Vols. I-VI, 1970-71.
34. Alix, J.P.: Problèmes de Définition et d'Adaptation. Le Centre Local de Santé.
35. Canada: Quebec: Bill 65: An Act respecting Health Services and Social Services (now Law 48.)
36. Anderson, D.O.: Personal communication.
37. Gilholme, K.R. and Newell, D.J.: Problems and Progress in Medical Care, Edited by Gordon McLachlan, Nuffield Provincial Hospital Trust, Vol. 5, Oxford University Press, Oxford, March 1972.
38. Palmer, E.: Keeping the Options Open. Br. Hosp. J. and Soc. Serv. Rev., pp. 2044-5, Oct. 2, 1971.
39. Arenillas, Luis: Emptying Subnormality Hospitals. Br. Hosp. J. Soc. Serv. Rev., Dec. 18, 1971.
40. Pasker, P. and Ashley, J.S.A.: Interrelationship of Different Sectors of the Total Health and Social Services System. Community Medicine, No. 3302, Vol. 126, No. 20, Nov. 12, 1971, pp. 272-276 and 265.
41. Willmott, Peter and Young, M.: Family and Kinship in East London. Pelican, London, 1962.
42. Klein, Rudolf: The Political Economy of National Health, Report from London: The Public Interest, pp.112-125, Winter, 1971.

CHANGES IN USE OF ESTABLISHED SERVICES AND OTHER INNOVATIONS

It was thought to be important for the Community Health Centre Project to examine the innovations in institution in the ambulatory care sector in recent years in order to see what professionals and patients were trying to change in the present system of delivery. A series of case studies was commissioned.

EMERGENCY ROOMS AND HOSPITAL OUT-PATIENT DEPARTMENTS

It would appear that emergency rooms are the safety net of the medical care system. New⁽¹⁾ who reviewed studies of changes in their use in recent years, says "Many persons who use the emergency room services view it as a place where they can receive primary as well as emergency care. In the reported studies, usually 7-10% of all cases are emergent, another 30-40% of the cases are urgent and the remaining non-urgent, by standard definitions of what physicians consider as criteria of emergency. A second fact from most studies is that emergency room use is rising at a far greater rate, even taking into account population increase, than other hospital usages, including in-patient, out-patient clinics, etc. Thus some of the patients undoubtedly view emergency rooms as places where primary care is delivered... Emergency room use has to be seen in relationship to specific population groups and also... within the context of the other health agencies which surround the emergency room..."

"In Toronto, the experiences of the clinics in the Chinese and the Portugese areas are that the local citizens utilize these because some of them do not know how to cope with and have little knowledge of the (doctors' offices and) hospital settings as places to receive care."

Anderson⁽²⁾ points out that some confusion may exist about the purposes of emergency rooms and out-patient departments because of the historic position of out-patient departments in some of the large hospitals in city centres before medicare was introduced. For example, at the Vancouver General Hospital, a comprehensive charity clinic gave service to the medically indigent. Elsewhere dispensaries were attached to the hospitals.

New continues: "From the most extreme point of view, it can be said that emergency rooms are community health centres. Because emergency rooms in most large hospitals are operated all the time, the population has access to these at any time. At the same time, as they now exist, emergency rooms do not really function as an integral part of the health system. They are seen as providing ancillary-emergency services only. Thus the allotment of space, the allocation of personnel and the reimbursement schemes are all structured as separate parts of the larger whole, usually a hospital...

"There is some evidence that physicians, especially those who do not have hospital appointments, are using emergency rooms as their own offices or are sending patients to emergency rooms to receive care that they cannot render in those hospitals.

"As most emergency rooms are structured now, they presumably provide service that 'standard' health care institutions do not provide. Yet because of the demands, hospitals are now trying to staff emergency rooms with full-time hospital-oriented personnel. In essence these hospitals are creating hospitals within the hospital, or creating a full-time clinic within the hospital to deliver ambulatory care rather than solely emergency care. How patients and staff view emergency rooms affects the utilization of these places."

"In America, newly established Neighbourhood Health Centres have drawn off clients from emergency rooms but there is some evidence that users of these clinics also use emergency rooms and hospitals... This seems to suggest that community health centres may be used simultaneously with other health facilities including private physicians' offices."

New says, "The main difficulty in discussing emergency room function is how one perceives their functions and how emergency rooms exist in the structure of the health system.

"This (use of emergency departments as well as or instead of doctors' office services) brings up the question of pathways that patients take to seek care before they enter into the health system. Increasingly, we are recognizing that patients do not necessarily seek help from what society deems as the most competent and qualified health resources, such as physicians or hospitals. Nor do patients seek help in what we may consider as a rational way. They use a variety of resources and, depending on what they hit on first, they may then take some path which may

or many not ultimately lead them to a physician. Along this route, certain barriers are encountered which may send the patient off on another tangent."

"In one sense, these barriers or gates are erected by the health professions or health institutions themselves. Such accepted routines as appointments, referrals, and hours when patients are seen may be seen by the patient as barriers. Medical centres consisting of complex functions may be highly desirable from the standpoint of health professionals, but they are seen as a maze of corridors with anonymous workers behind different colored doors by patients. The proper channelling of patients through this maze, with required forms and schedules, can easily be interpreted by patients as non-welcoming signs rather than part of the smooth flow of patients through to the next station. All these can be defined as part of a hostile environment by persons not acquainted with the health system,

"Thus even before the patient has a chance to pass into the health system they are blocked, or at least they perceive some blockage; they repair to simpler modes of seeking health care into the emergency rooms."

New does not focus attention upon the problems which middle-class patients also have, perhaps because these have not been much studied in Canada: Many of these patients are having to seek emergency room services for urgencies, either because their doctor closes his office in the evening and at weekends and will not do house calls, or because they move to a new town and find that all the practices are "closed".⁽³⁾

In some places, personnel in medical arts buildings and large group practices have tried to meet this demand for urgent care by developing dressing rooms which are always open for the patients of doctors working in the building⁽⁴⁾. The doctors have a rota system for manning this service.

The hospitals themselves seem to be anxious to develop their emergency rooms rather than close them down or narrow their function to deal only with disasters. In a discussion with hospital administrators it was made clear that they wished to see their emergency rooms developed into community health centres.⁽⁵⁾

"But", New continues, "hospitals and established health care centres apparently are not viewed by some segments of the public as being able to cope with their problems. This is certainly what happens to the young who eschew these places in favour of the free clinics, and the recent immigrants are intimidated by their inability to sort out the routes to take or whom to see in these places."

YOUTH CLINICS

Tonkin(6) has described the street and free clinics which developed in British Columbia. He identifies the major areas of need which each tried to meet:

1. "assistance with survival: information, housing, nutrition and income;
2. health education and care in the problems of sexuality and reproduction;
3. legal aid and crisis aid, especially related to drug abuse;
4. primary care for minor episodic illness and infectious disease including hepatitis, lice, URI's, skin infection, etc;
5. emergency care for trauma."

He reports: "Many of the alternate resources developed to meet the needs of youth have operated outside of the funding and professional constraints of the larger system. As part of the "alternate society" movement, free clinics represent an attempt to develop a new organization but seem to end up by looking very much like an O.P.D. but with less to offer. It is likely that the need for change within the system has been made less pressing by the development of these alternate resources. Certainly the response of the traditional elements of the health care system has been hard to detect...for these centres have not had a major impact on the total health care system."

He divides young people in search of services into two groups - the counter-culture of transients and immigrants and traditional youth. Both have unmet needs but "traditional" youth often has access to insured services, to their family

physicians, while alienated youth are usually "medically indigent" and eligible for only care from O.P.D. and emergency departments.

For the 10% of medical problems which are traumatic, the emergency departments are used, for the 90% of other problems they are not. "For many...these facilities represented an alien and unsympathetic resource...Often, especially in the area of drug abuse, the skills and resources of these departments were inadequate..." "Traditionally" youth have problems which they do not wish to bring to the attention of their family physicians, e.g. V.D., contraception, abortion. Particularly in the area of soft drug abuse, lay and self-help groups have become involved. Street services and alternate types of health care have sprung up in the city of Vancouver. The V.D. service have radically altered their style and continue to play a major service role. A 'detached' nursing service has been developed working out of the public health department. Special kits of literature and medical supplies have been made available to all offices. Between June and August, 1971, 698 transients were seen; one-third in public health offices, the remainder at youth hostels. The majority (389) came because of minor injury, illness, skin infections or intestinal disorders; 107 were seen for suspected V.D., 89 for general health information or advice on finance, 51 for contraceptive advice, eight because of emotional disturbance and eight for drug abuse. (7)

CLINICS FOR SPECIAL NEEDS?

Some evidence that there may be differences in the needs of different age groups was produced by Sternlieb and Munan⁽⁸⁾ who surveyed some 1400 young adults in Quebec. They found that 40.2% of their respondents would like to have had a youth service serving all younger age groups. There was a difference in the response of workers, training centre and university students, from those of junior college and high school students, the latter wanting the special youth services. Youth clinics were perceived to be specialist information centres for sex education, drugs, V.D., alcoholism, family planning and contraception. Problems the respondents would like to have had solved were 'nervousness' 29.2%, dental problems 27.2%, menstrual problems 10%, acne 18.3%, health worries 9%, headaches 8.9%, obesity 5.9%, V.D. 0.7%, other 7.7%.

Sternlieb and Munan examined in detail the respondents' listing of 'personal problems'. They suggest that the problem of 'nervousness' shares many of the characteristics of the personal problems listed, "as such it becomes a disease and falls out of the category of entities accessible to traditional medical approaches and into that with social etiologies... In practical terms... this means that the youth clinic as presently structured with its medical orientation, may be more suited to handling the problems with biologically based etiologies than in confronting the totality of problems... In all, 535 responses out of 1181 respondents related to practices of consulting medically unqualified persons... on matters of health." (They may have consulted both: the questionnaire did not distinguish). "Major personal problems of youth brought out by this study are not of drug use. They are, rather, associated with the social institutions and relationships into which the young are initiated, with which they are trying to cope or from which they are trying to be severed."

Studies of the use of family planning clinics also indicate the need for an easily accessible and technically sound service.(9)

In another study in the same area of Quebec, Vobecky, Kelly and Munan(10) found that only 65% of elderly people were getting service from a physician. It is thought that the problem of neglected old people is not dissimilar in British Columbia.

STUDENT CLINICS

The student clinics, which reached the height of their popularity in Canada in 1967-69, were developed, says Szasz(6), in a special climate of student radicalism. He has examined the documents which describe the origins of these projects, in the university towns of Vancouver, Winnipeg, Edmonton, Toronto, Montreal, Sherbrooke, Ottawa, Kingston and Halifax. "The combination of personal needs, social forces and timely opportunities which have stimulated individuals or groups of individuals are complex and probably not even recognized in retrospect..." He says that he doubts the validity of the list of reasons given for establishing these projects. He believes that "certain projects were established mostly because of the students' unfulfilled personal needs. The need to control others, to release

frustration with the educational system or to excel in a new and different field may have been more compelling reasons than any of the documented needs for new types of health care services".

"The playing out of personal needs resulted in some very strongly action-oriented, poorly organized, often haphazard projects, which were often stamped by the personalities of the initial workers, many of whom were labelled 'student activists'. The 'student activism' label has often held back faculty members and, in fact, a majority of students from becoming involved in a form of practice or social action which might be considered 'different'".

OTHER NEW MODELS

Before leaving the discussions on innovation, it is important to stress again:

- (a) the demonstrations of the expanded role of the nurse
- (b) the CELDIC concept which moves out beyond the health centre facility and into the community itself. It develops a broad concept of health care which challenges the present professionally oriented, institutionally centered models. As Coates⁽¹¹⁾ says, "Mental health problems should be regarded as primarily manpower rather than technological or institutional problems"... His chart explaining the CELDIC orientation appears in Chapter 2 (Chart 3).

ANALYSIS OF THE CASE STUDIES

The CHC Project commissioned case studies on innovative developments. New⁽¹²⁾ who was asked to analyse the case material did not examine the community sponsored group practices but chose to look at:

- (a) Some employee health services (company town services) which have now been developed to serve local communities

- (b) Hospital emergency departments
- (c) Youth clinics
- (d) Student clinics
- (e) Quebec CLSC
- (f) Clinics developed to serve minority ethnic groups.

He perceived that the newer centres were "a response to political unease, citizen demands for health care, medical student unrest, general disenchantment with the medical establishment and a desire for local control. The growth of these centres is partly due to the general decentralizing process of health services and partly to health problems encountered by specific population groups, such as drug use among youths or breaking the poverty cycle among the poor".

"Thus", he continued, "a community health centre is not just another health delivery service consisting of clinical and organizational components, but (it is viewed by me) as a political organization as well. It is a place where concerned citizens and health professionals, alike, would like to exert some control over the management and operation of the centre. Up to now, most health service organizations have been controlled by the professional staff. To be sure, hospitals and social agencies dealing with health have "lay" boards, which deal mainly with financial, planning and possibly inter-agency institutions. Now, an increasing number of citizens want control over the day-to-day operations of health institutions, especially those with the word 'community' attached to their names. However, citizens and professionals have different degrees of involvement and different perceptions of ideal amounts of involvement in the political and health delivery aspects."

He proposes the use of two paradigms (Charts 12 and 13) to explain the differences of perception of professionals and citizens who are involved in the innovative health centres.

Chart 12

PARADIGM I: PERCEPTION OF PROFESSIONALS ON CONTROL OF
ACTIVITIES IN COMMUNITY HEALTH CENTRE

CONTROLS OVER ACTIONS

		Health delivery		
PERSONS INVOLVED	Citizens	Political	Clinical	Organizational
		Participation	non-involvement	minimal participation
	Professionals	non-involvement	control	participation

Chart 13

PARADIGM II: PERCEPTION OF CITIZENS ON CONTROL OF
ACTIVITIES IN COMMUNITY HEALTH CENTRE

CONTROLS OVER ACTIONS

		Health Delivery		
PERSONS INVOLVED	Citizens	Political	Clinical	Organizational
		control	participation	control
	Professionals	involvement	advocate	minimal control

He points out that, in general, the new centres have had a stormy existence. "They may be seen as well-defined structures or organizations, but at the same time, they may also be seen as events that come and go."

"While we recognize the dangers involved in the use of paradigms to explain events, they may help to clarify the reasons why some of the existing community health centres are

faltering or in danger of collapsing. The paradigms best represent what takes place in centres which (1) have evolved out of community demands, and (2) have been established by forces outside of the community and, at a later point in time, have been subjected to community demands for control. In Canada, the first could be exemplified by the North End Clinic in Halifax, Nova Scotia. The second is typified by le C.L.S.C. d'Hochelaga-Maisonneuve in Montreal, P.Q. Although most of the community health centres in Canada follow fairly traditional lines of professional control and operation, in the future there is good probability that some community residents may want more of a voice in the daily operations.

"Citizens and professionals perceive problems of control differently. Professionals are most concerned with control over the clinical aspects of health delivery. They are well-trained in this area and they justifiably feel this is their domain. For those physicians who work in community health centres the more that their practice approximates solo practice, the happier they are. In the clinic at Churchill sponsored by the University of Manitoba, even though team work is stressed, physicians find it difficult to accede to this. Even in Pinawa Hospital, a "company town" operation, where physicians are encouraged to refer cases to each other, this is seldom done. For physicians who specialize, Dr. Ursula Anderson^(1c) finds that paediatricians and family physicians have difficulties in working together. Thus, when it comes to the matter of controls, physicians act as a closed corporate group over clinic operations. The preferred mode of operation is indeed "hands off" from the citizens."

New goes on to say that, on the other hand, most health professionals, especially physicians, do not really want to spend time in dealing with the political problems of operating a community health centre. They may be glad to leave the citizens on the sponsoring boards to participate in the political arena, to try to get more resources for them. "As far as management of health delivery is concerned, professionals want some participation, but not necessarily control over all spheres of organizational management. They would probably tolerate minimal participation from citizens, such as over the choice of para-professional staff or how the space in the waiting room is to be allotted."

"The perception of interested citizens is quite different. We hasten to reiterate that most community residents are apathetic over the fate of the health centre. For instance, even at the North End Clinic, most of the citizens really have little involvement in the operations of the centre. They would just like to have health care whenever they want it. For the interested and involved citizen, however, they want total control over the political spheres and the management of the health centres. In the clinical area they would like to have some participation, recognizing that many strictly medical routines are beyond their capabilities. However, citizens do not view health services narrowly, involving physicians only. They feel appropriate functions could be carried out by non-physicians, such as nurse practitioners, medical assistants, and health aides of various types.

"Citizens also feel that health professionals should be involved in the political area because here is where the professional could lend his prestige in getting money or influencing legislators, or even holding press conferences to tell the rest of the world how awful current medical services are. Citizens would like health professionals to be their advocates in the clinical area and should have some participation in the management of the health centre.

"The main reason citizens would like to have professionals involved in the political area arises from the fact that the citizens do not view the health centre as a place where only health care is delivered. From this standpoint, the suggestions put forth by the Castonguay Commission come close. It views the 'communautaire locale' as a place where many different functions are carried out, in the area of housing, education, recreation, social services, besides health. Some citizens in Quebec Province want this scheme of delivery carried out even further, by direct funding to local citizen groups rather than through some intermediate agency. In other words, they want total control over management and over the political spheres.

"Most health professionals, of course, see community health centres operating only in the service area. The centres should deliver high quality and competent care. For the few health professionals who adopt the advocacy role, they are labeled as "deviants", or even traitors, by their peers.

"We feel these paradigms may explain the conflicts and problems which occur in community health centres. The goal of delivery of health services to all may be the same for both citizens and health professionals, but they differ in the ways to arrive at these goals."

SUMMARY

Innovative services other than community clinic (group practice) models have been developed as follows:

1. Emergency rooms. These are the safety net of the medical care system: 7-10% of cases are urgent, 30-40% emergent and the rest non-urgent. The rate of use is rising. Some users may be unable to cope with the formalities of doctors' offices, others may have become used to hospital out-patient departments in the days of charity clinics. Some physicians use emergency rooms as their offices. Patients may use emergency rooms in addition to other services. It is important to consider how people perceive and how they get to emergency rooms and what function they serve in the total system. What are the barriers which make patients unable to cope with doctors' offices or, in the case of young people, even with emergency rooms, so that they want their own youth clinics. Hospitals seem to be keen on developing emergency rooms into community health centres.
2. Youth clinics. These were developed to meet the following needs: assistance with survival, health education particularly in problems of sexuality and reproduction, legal aid and crisis aid particularly related to drug abuse, primary care for minor episodic illness particularly infections, emergency care for trauma. They were part of the counter-culture movement. Youth clinics provide a low standard of service but seem to have been able to meet the needs of this group.

Surveys indicate that special clinics may be useful for particular groups - young people, old people, and for family planning advice.
3. Student clinics. These were developed between 1967-69 in university towns in a special climate of student radicalism. It appears that certain projects were established mostly

because of the students' unfulfilled personal needs and the playing out of these personal needs resulted in some very strongly action-oriented, poorly organized often haphazard projects. The student activism label hindered the development of some of these clinics.

4. Demonstrations of the expanded role of the nurse.
5. The CELDIC model. This presents a broad concept of community health care which challenges the professionally oriented, institutionally centred models. Mental health problems are primarily manpower rather than technological or institutional problems. A chart (shown in Chap. 2) indicates how cases may be found, dealt with and lost.

Case studies were also made of a company town in Manitoba, three Quebec C.L.S.C. which had come into being, and several other clinics developed to serve minority ethnic groups. New perceived, that these newer centres were a response to political unease, citizen demands for health care, medical student unrest, general disenchantment with the medical establishment and a desire for local control. A community health centre has medical, clinical and organizational components but it is also a political organization. The views of physicians and of clients about control are not the same. Most community residents are apathetic about health care delivery but some, particularly some minority groups, think that the medical profession could be more sympathetic, even might become advocates for their needs. They do not feel that health centres are only for medical care but could be centres of social advancement.

REFERENCES

1. New, Peter K: The Relationship of Emergency Services and Community Health Centres: One Perspective.
 2. Anderson, D.O: Personal communication.
 3. LeRiche, H. et al.: People Look at Doctors and Other Relevant Matters. The Sunnybrook Health Attitude Survey, Sunnybrook Hospital, Toronto, Ontario, 1971.
 4. Smith, Neville S.H.: Ambulatory Health Care, The Views of a Clinic Physician.
 5. Rosenfeld, G.B.: Summary: Seminar on Relations Between Hospitals and Community Health Centres.
 6. Tonkin, R., and Szasz, G.: Two Views of Community Health Centres.
 7. British Columbia: Department of Health and Hospital Insurance: Health Branch Annual Report, 1971.
 8. Sternlieb, Jack J. and Munan, Louis: A Survey of Health Problems, Practices, and Needs of Youth. Pediatrics, Vol. 49, No. 2, p. 177-186, Feb. 1972.
 9. MacKenzie, C.J.G.: Birth Control in Canada.
 10. Vobecky, Josef, Kelly, Anthea and Munan, Louis: Population Health Care Practices: an epidemiological study of physician visits, hospital admission and drug consumption. Submitted for publication to Can. J. Public Health, 1972.
 11. Coates, D.: Mental Health Aspects and Primary Health Care.
 12. New, Peter: Community Health Centres: Five Danger Signals (Summary of case studies and commentary).
- Case Studies. Confidential, not available except to Project Staff. New and Fish.
- (a) University Settlement House, Toronto
(b) The Niagara Clinic

- (c) Resumé of information on Community Health Centres of the Hospital for Sick Children, Toronto.
- (d) Halifax North End Community Health Clinic, Nova Scotia.
- (e) Supplementary Report, North End Health Clinic - Halifax.
- (f) Second Supplementary Report, North End Health Clinic - Halifax.
- (g) University of Manitoba Northern Medical Unit, Churchill.
- (h) Manitoba - Mount Carmel Clinic - Winnipeg, Manitoba.
- (i) The Blackhead Road Health Centre, St. John's, Newfoundland.
- (j) Student Health Service, M.U.N., St. John's, Newfoundland.
- (k) International Grenfell Association, St. Anthony, Newfoundland.
- (l) Description des centres communautaires de santé:
 - 1. Le Centre de Grande-Vallee;
 - 2. Le C.L.S.C. d'Hochelaga-Maisonneuve;
 - 3. La Clinique St. Jacques.
- (m) Morley Reserve Health Centre.
- (n) St. Catharines Community Health Centre Foundation.
- (o) Ottawa and District Community Health Centre Foundation.
- (p) North Preston Clinic: A Case Study.
- (q) Two Views of Community Health Centres. Student Centres and Innovations in B.C.
- (r) Community Clinics in Saskatchewan.
- (s) The Reach Centre, Vancouver.
- (t) Medical Services in a Company Town (Pinawa Hospital).

STRATEGIES OF CHANGE AND ONGOING PROCESS OF CONTINUOUS ADJUSTMENT

Certain of the information contained in this chapter has been discussed previously. It seems advisable, however, to restate it in introducing the discussion on strategies of change.

THE OBJECTIVES

The reasons given for reorganization of the existing system of health care seem to fall into two main categories:

- (a) Systematic planning is likely to ensure that better use is made of resources.
- (b) There is some political pressure for a redistribution of power among professionals and from professionals to the public.

In order to meet both of these objectives, reorganization would be necessary at two levels:

- (i) the system level, and
- (ii) at the point of delivery of services where patients meet professionals and service is given.

SOME PROBLEMS WHICH GOVERNMENTS WISH TO SOLVE

Many arguments in favour of setting up community health centres are systems arguments. It is clear that setting up more centres, however well organized, within the present system, are unlikely to improve dramatically the health care of Canadians, for it has been demonstrated that the failure lies in relating the different parts of the service to each other so that resources are used effectively. It is also very difficult to establish new forms of delivering care because of the administrative and legal barriers set up by the shared-cost fundings, fee-for-service payment systems, licensing, registration and other legal provisions.

A number of systems problems can be identified. To recapitulate, these are:

- (a) incentives to physicians, patients and hospitals are all in favour of filling hospital beds. There is no generally accepted set of criteria for determining what are emergency, urgent, and elective cases for admission to hospital. Hospital beds are unevenly distributed and, consequently, different criteria are applied in different places. Some provinces have a declining population and a good supply of hospital beds overall, other provinces with growing populations are hesitant to open new hospitals (being aware that efficient care can be given with a ratio of two or three beds per thousand population instead of having a ratio of six to seven per thousand as in some provinces but there is strong pressure from rural communities to have local hospitals. Rural communities do not seem to take readily to being made to have out-patient services only and Canada's distances and the winter snows prevent the easy solutions available to countries with populations living in close proximity and with milder climates. People seem to wish to have in-patient beds at the primary care level and this may be technically necessary for isolated districts. It may be politically necessary in less isolated places for, if these are regarded as important electoral communities to the provincial politicians, then existing hospitals are unlikely to be closed down and new hospitals may even be built.*

* The British Columbia Hospital Insurance Commission has recently been experimenting with designs for small rural units. The basic module is a diagnostic assessment and treatment centre for simple medical work. It houses the doctor's office, examining room(s), a dressing room and 3 day beds. To it may be added seven more beds and a kitchen facility in the second module. This addition was intended for isolated communities as an in-patient facility, but the politicians are under great pressure to put in 10 bed units wherever any facility is being constructed.

- (b) In the large urban centres there is often a relative shortage of beds, and hospital privileges and waiting lists become 'political' matters. It is partly because of this contrast between urban and rural areas that questions are beginning to be asked about definitions of out-patient facilities, hospitals and nursing homes; and about the systems linkage of primary, secondary and tertiary care.
- (c) It would appear that many cases should be given day care only and experiments with day surgery and day hospitals for the mentally disordered, geriatrics, etc. are being tried out in some provinces where beds are short and physicians are open to new ideas. However, it costs the patient or the patient's family more to keep him out of hospital. A social support service and an escort service may be needed for development of day care.
- (d) Many hospitals insist on repetition of diagnostic tests made in doctors' offices or in other laboratories and x-ray departments than their own for reasons of legal coverage. This increases hospital bed use during workups. Co-ordination is obviously needed.
- (e) Presently physicians are unevenly distributed. Provincial Colleges of Physicians and Surgeons have not been able to find methods of achieving a satisfactory distribution of physicians in their jurisdictions. Short of compelling doctors to move, there are only two measures which can be applied: (i) incentives to work in unpopular areas: (ii) prevention of new entrants from setting up practices in 'over-doctored' areas. In countries where there is a national health service, there is considerable experience of trying to develop distribution schemes but they have not been outstandingly successful because the market for physicians' services is a world market and if any one jurisdiction tries to impose too many terms and conditions on service then doctors will migrate.

The prospects of getting an adequate number of physicians to work in remote areas are not great. Some will go because they wish to work there, because they like the life or because they wish to do 'missionary' work.

Some may respond, temporarily, to incentives. But it seems unlikely that the problems of distribution of physicians can be solved without some kind of physicians' assistant scheme. Development of a sorting and referral service by physicians' assistants with consultancy from physicians would make better use of physicians' skills in outlying areas. Physicians might be willing to become full-time or part-time travelling consultants linked by radio-telephone and air transport to outpost clinics when they would not be willing to do full-time clinical practice in one remote centre.

- (f) Too many specialists are overtrained for the work they are doing. The training of specialists is for tertiary level work but many are giving a mixture of primary and secondary care. More help needs to be given to physicians with career planning and choice of specialization.

More information is required by the provinces, the medical associations and colleges, and the universities to plan with and for the specialists.

- (g) Delva⁽¹⁾ has estimated that 20% of Canadians are 'have-nots' with special needs for more care than others. Some of these 'have-nots' live in out-post areas, some in city centres. Governments are uncertain whether they should do more for these people, i.e. try to bring them more into the mainstream.
- (h) Can Canada afford to continue with the policy of completely free choice of physicians without any deterrents? Presently this policy results in lack of continuity of care, overuse by some, and underuse by others in the fee-for-service system. Capitation payments to clinics, paid without conditions of lock-in or endorsement, can lead to trouble too. One of the pioneering community health centres which was started by the U.A.W. at St. Catharines, negotiated capitation payments with the province of Ontario on the strength of the union knowing its membership. However, the union members association who may have been very loyal to the union did not all feel this same sense of attachment to the clinic. Because they were not enrolled to use the clinic exclusively many felt free to make arrangements with other physicians. The Sault

clinic set up by the Steelworkers met with similar difficulties. The Provincial government found it was paying twice, once for capitation payments and once to the other doctors for their service fees. There are a number of administration advantages in bed capitation or enrolment. Providers - government, sponsors of clinics, individual physicians - can plan ahead. Not only is it easier to calculate budgets but it is easier to develop analyses of the physicians' work, for the non-users can be identified and the confusion presently created by the medical care shoppers eliminated. Without enrolment the concept of continuity of care - surveillance, maintenance and restoration - is much less easy to achieve, for the inarticulate, unsophisticated lower socioeconomic group member gets lost between the various parts of the system. Freedom of choice becomes illusory or individuals make poor choices.

- (i) Many people are concerned about the problem of getting doctors' services when they (the users) perceive an urgent need for help. The hospital emergency rooms may be the only resort and in many cases they are not sufficiently well organized to please the upper and middle classes. Nor do emergency department staff have the time or the skills to deal with many other problems which are presently being brought to them - e.g. drug abuse.
- (j) Another problem is the urgent need of those people who move to new districts to find a physician whose practice is not "closed".
- (k) Finally, what should be done to set priorities? There are no generally accepted guidelines about when to let patients die⁽²⁾ or how much to do for the old, or the disabled vis-à-vis prevention.

AVAILABILITY OF RESOURCES: SYSTEMATIC PLANNING

Roth⁽³⁾, in a paper written for the Project, said: "On all sides there are demands to find means of limiting expenditures, of finding cheaper ways to provide care... We should

ask ourselves whether the public wishes to spend more or less on health care. It may be that they are not only willing but are anxious to expend more of their resources in the health field: they may want to support such new and more effective means of providing care as community clinics, domiciliary programs, etc."

However, there seems to be no evidence to show that Canadians are willing to pay more or less for health care.

Klein⁽⁴⁾ has argued that, although the planning and control of government expenditures has become considerably more sophisticated in the last decade, it is doubtful whether this makes much difference to the decisions eventually reached. "The two main determinants of the global figures of spending remain much what they have always been: last year's budget and the general state of the economy." Health services are likely to be allocated much the same proportion of the G.N.P. as they were allocated last year - any change is likely to be within a narrow band, for health is in fierce competition with other government services for a share of the total redistribution of tax monies. A slight increase or decrease in the share may be related to the strength of a particular minister or the political salience of his programs.

If Klein is right, it seems very unlikely that the share of national income devoted to health care will be increased now that a "comprehensive health care program" has been established. Other "essential" services will claim their share and the national income will be redistributed in much the same proportions as before.

It would appear that, in Canada, the time has now come when the budgetary resources allocated to health and welfare services are fixed within "the narrow band" of possible adjustment which Klein mentions. The only difference may be a redistribution within the health and welfare budgets as a result of administrative decision-making.

Consequently, the discussions of what should be included in the concept of health or health care become important because redefinition may precede attempts to change resource allocations.

Self⁽⁵⁾, a British professor of public administration, has argued that, "although a great deal is known about

political processes, very little is known about administrative processes in government. Some methods of business efficiency apply inside government but the goals of government are much more diverse and far ranging; the methods of making decisions and allocating resources are very different (from those of private enterprise organizations): and concepts of efficiency must relate to these conditions...(whilst) the first rule of business is market innovation, the government equivalent could be said to be market compression - keeping all public demand within a certain global sum. This is too simple, no doubt, but perhaps it is suggestive.

"The modern democratic state is not the towering monolith pictured by many contemporary exponents of political protest, on the other hand, neither is it a welfare state - if that implies a high measure of egalitarianism or close attention to the needs of the unfortunate. A government which did much less in general, could achieve much more in these respects.

"...The system is pluralistic in the sense that each agency has some (though varying) autonomy and that their respective policies are often conflicting and contradictory. Some reasons for this are that inconsistent political demands become frozen in political action;...each agency must, to some extent, adjust its activities to specific sources of support and opposition:...each agency is influenced not only by its history, organization and balance of tasks, but by its professional resources."

Reviewing the British experience of health care planning in the last 10 years, Klein makes a tentative comment: "...the experience of what may be called macro-resource planning suggests the difficulty of carrying out such an exercise successfully when it is seen primarily as an attempt to adjust the internal priorities of the health service to resources determined by external factors (i.e. Cabinet decisions on the share of the G.N.P. which is allocated to health care)...It suggests that, in the long run, it may be necessary to reverse this approach: to construct a series of internal priorities, expressed perhaps in terms of specific objectives as the advocates of PPB propose, which are then carried out to the extent that the availability of resources permits....

"The experience also suggests that it is difficult to introduce a new set of priorities when these lack coherence..."

Klein admits, however, that "there is always the danger that putting too much reliance on PPB and similar methods may divert resource to these sectors of health where objectives, inputs and outputs are most easily quantifiable... Another conclusion... is that resources allocation in effect means bargaining. The process of determining priorities is essentially a process of reconciling different interests:.. an ongoing process of continuous adjustment".

GOVERNMENT APPROACHES TO CHANGE

Just because Canadian governments have taken over the responsibility for financing the operating costs of hospitals and paying physicians, it does not mean that they are in control of health services. The system continues to operate much as it did before. But there are beginning to be some questions asked about the present system which subsidizes hospitals and the medical profession without apparently imposing sufficient controls over efficiency and effectiveness.

Despite the fact that most Western nations have given a mandate to their governments to take over the main responsibility for funding health services "an implicit philosophy of incrementation has been adopted, that is, of small feasible changes made within the framework of existing health services", says Badgley(6).

Popper(7) has suggested that the values of a society can be changed more rapidly than its institutions. It would appear that the politicians in most provinces are already trying to change their constituents' values vis-à-vis the medical profession and their methods of delivering care, to "legitimize" new approaches, but even if constituents' attitudes change, the professionals' institutionalized resistances will remain.

Governments may legislate for change, or they may prefer to proceed by negotiating directly with power groups who control the resources of a service. The only advantage of legislating is that it sets down objectives, and once these have been passed through the legislature there is a commitment for future governments as well unless they decide on repeal.

But even when a government legislates it has to come to terms with the power groups, as the Saskatchewan government

found in 1962 when the physicians refused at first to comply with the new act introducing Medicare. It was easier in 1966 to absorb the insurance schemes into the Federal Medicare scheme than to fight them.

Because the governments now have greater control of the purse, some power has shifted into their hands from the medical profession and the hospitals i.e. power to reward as well as power to legitimize by statute. But at the same time there is some disillusionment with governments, with the democratic process which puts politicians into power in Canada. This disillusionment is expressed in a demand for decentralization to local levels and direct representation of 'consumers'. For those consumers believe they are not getting an adequate service. They want to know why they cannot get medical care in some rural areas or in the evenings and at weekends in the cities, or why so many health care institutions treat them so impersonally when they are looking for help from people who ought to show that they care. But the local people do not yet have much power (although they are promised autonomy in managing local health centres in Quebec).⁽⁸⁾ And, in general, it is only the few who recognize the possibilities of community power, though in Quebec animation sociale is endeavouring to strengthen community concern about professional practice.

Health professionals' groups other than physicians are also expressing dissatisfaction with negotiated bargains limited to governments and the medical profession. Nurses and pharmacists are complaining that a subsidized entrepreneurial medical care system prevents them from optimizing their professional skills. The dental profession, chiropractors and others have been unhappy that almost all of the subsidies have gone to physicians and to hospitals where they work. They would like to have had some share of the financial resources redistributed by governments.

HOW POWER MAY BE REDISTRIBUTED - A SOCIOLOGICAL EXPLANATION OF DEFENCE MECHANISMS

RATIONALITY AND OTHER RATIONALES

Resistance to change is to be expected from established groups and entrenched institutions when these anticipate losing power in times of change. Roth⁽³⁾ warns that the present

decentralization of decision-making in the medical care system enables organized interest groups to hinder the development of an efficient rationally planned system.

Many sociologists have drawn attention to the multiple levels of functioning in organizations. It cannot be assumed that the overtly expressed formal goals of an organization are the only goals that have to be considered. Dubin⁽⁹⁾, for example, suggests that there are four behavioural systems operating within organizations all at the same time. He calls these the technological systems which sets up patterns of work, the formal authority system, the non-formal system (the shortcuts that people take to get things done) and the informal or social system which is directed towards personal satisfaction, not organizational goals.

Others have discussed the difficulty of aligning the goals of small groups within organizations with the overall goals of the undertaking.

Differences of opinion about the importance of reaching a series of goals and the best method of organizing teams in order to attain them tend to be more difficult to resolve in ambulatory care settings than in the more high-risk para-military sectors of hospitals. New⁽¹⁰⁾ has pointed out that substantive issues are often left ambiguous, are not worked through, by the members of teams and these ambiguities are stressful to live with.

Selznick⁽¹¹⁾ points out that threatened groups or organizations will develop defence mechanisms to defend their security. Program achievement may become less important than survival.

The way in which individuals use defence mechanisms has been made clear by psychiatrists in books such as Berne's "Games People Play"⁽¹²⁾. Sociologists have studied the defence mechanisms used by groups or organizations. Unfortunately they do not write so amusingly about their findings.

IDEOLOGIES

Selznick points out that in order to cope with the stresses - the tensions and dilemmas that result from pressures to change groups will use defence mechanisms to sustain the stability of

informal relations, to maintain continuity of policy, and homogeneity of outlook about their meaning and role in society.

The defence mechanisms which will be used, says Selznick, are groups' ideologies. Blighen's analysis⁽¹³⁾ of Canadian doctors' doctrines was mentioned in an earlier chapter, but there are many other ideologies which are also important - the "voluntary" hospital concept, the "need" for in-patient hospitals in small centres of population, "teamwork", "consumerism", "democratic processes". The question is how to strengthen the ideologies which should be strengthened and weaken those which have to be changed if new objectives are to be reached.

Selznick makes it very clear that rational planning by government can only go so far. The rational approach to relating means and ends constrains those involved from taking account of the consequences which indirectly shape the means and ends of policies. For individuals and sub-groups have rationales different from those of the planners. They have vested interests or commitments.

"Commitment", Selznick says, "is a basic mechanism in the generation of unanticipated consequences...(consequently) it will be difficult to reach rational objectives by rational means." He speaks of the tangential effects which must be expected in developing new social policies. There will always be unintended consequences. It is much easier to start to build up new organizations than to change existing ones because the adaptation of an already existing organization will meet with resistances from those who are already committed to specific goals or specific means. "Free or scientific adjustment of means and ends is effectively limited. Constraints imposed by the system will be emphasized".

Within organizations, structures other than the planned formal organizational structure will develop -- structures which will reflect the spontaneous efforts of sub-groups to control the conditions of their existence.

CO-OPTATION

Organizations will also develop informal lines of communication and control to and from other organizations in the

environment. When an organization is threatened from outside it is likely to use the principle of co-optation as a mechanism of defence, that is "the process of absorbing new elements into the leadership or policy-determining structure as a means of averting threats to its stability or existence". It may be important for the future of community health centres to understand this process.

"This general mechanism (of co-optation) assumes two basic forms: formal co-optation when there is a need to establish the legitimacy of authority or the administrative accessibility of the relevant public; and informal co-optation, when there is need of adjustment to the pressure of specific centres of power within the community."

What does co-optation mean in practice?

If a new power group (e.g. consumers) is to be incorporated into the government-professional decision-making process, it will have real power only if it can operate informally. Formal co-optation is not real power-sharing but only a reaction to a political demand, an attempt to legitimize action. For example, the publication of doctors' incomes in B.C. was not real power-sharing with the public but an attempt to legitimate government action. Selznick says:

"The need for a sense of legitimacy may require an adjustment to the people...in order that a feeling of general acceptance may be developed. For this purpose, it may not be necessary actually to share power: the creation of a front or the open incorporation of accepted elements into the structure of the organization may suffice. In this way an aura of respectability will be gradually transferred from the co-opted elements to the organization as a whole and at the same time a vehicle of administrative accessibility may be established."

Real power-sharing changes are not usually overt: "When co-optation is to fulfil the function of an adjustment to organized centres of institutional power within the community, it may be necessary to maintain relationships which, however consequential, are informal and covert. If adjustment to specific nucleuses of power become public, then the legitimacy of the formal authority may become undermined. It therefore becomes useful and often essential for relevant public; and informal co-optation, when there is need of adjustment to the

pressure of specific centres of power within the community. Co-optation in administration is a process whereby either power or burdens of power or both are shared. On the one hand, the actual centre of authority and decision may be shifted and made more inclusive with or without any public recognition of the change; on the other hand, public responsibility for and participation in the exercise of authority may be shared with new elements with or without the actual redistribution of power itself. Failure to reflect the true balance of power will necessitate a realistic adjustment to those centres of institutional strength which are in a position to strike organized blows and thus to reinforce concrete demands. This issue may be met by the kind of co-optation which results in an actual sharing of power. However, the need for a sense of legitimacy may require an adjustment to the people in their undifferentiated aspect, in order that a feeling of general acceptance may be developed. For this purpose, it may not be necessary actually to share power: the creation of a front or the open incorporation of accepted elements into the structure of the organization may suffice. In this way an aura of respectability will be gradually transferred from the co-opted elements to the organization as a whole and at the same time a vehicle of administrative accessibility may be established."

Selznick suggests two hypotheses arising out of this: "(1) co-optation which results in an actual sharing of power will tend to operate informally and, correlatively, co-optation oriented towards legitimization or accessibility will tend to be effected through formal devices; (2) on the other hand, when co-optation is to fulfill the function of an adjustment to organize centres of institutional power within the community, it may be necessary to maintain relationships which, however consequential, are informal and covert. If adjustment to specific nucleuses of power become public, then the legitimacy of the formal authority may become undermined. It therefore becomes useful and often essential for such co-optation to remain in the shadowland of informal interaction."

The seminar on Legal Issues⁽¹⁴⁾ seems to have come to the same conclusions as Selznick that adjusting formal power is less significant than adjusting informal attitudes. Legal issues are often used as the excuse not to act rather than a mandate for action.

It is important to create more understanding of the processes of co-optation in order to diminish defensive reactions. There will be no rapid changes in present government - professional relationships. Governments recognize that real power lies with the professions and other existing institutions, that most consumer groups are presently quite powerless and that changes will have to be negotiated gradually. Meanwhile, governments will try to legitimate their own actions in negotiations by seeking voters' support and support from the few well organized consumer groups. One of their problems is that existing well-organized consumer groups (e.g. hospital boards) tend to be resistant to change themselves.

SHIFTS IN POWER FOLLOW SHIFTS IN OBJECTIVES

In regard to power sharing at the Community Health Centre level itself, experience has shown that community input comes mainly at the planning stage. At the operational stage the professionals are required to make executive decisions. Perrow⁽¹⁵⁾ has shown that hospitals tend to go through three stages -- from community input by trustees, through standard setting by physicians, to operational control by administrators. It seems likely that Community Health Centres may expect to follow this pattern too (see discussion in Chapters 14 et seq.)

SYSTEMS CHANGE

"One basic question which all governments must answer is whether community health centres should be developed in free competition (with the present system of providing care) and whether any limits should be put on the referral system," says Anderson⁽¹⁶⁾.

Should Canadian governments try to develop a parallel system of community health centres and entrepreneurial practices?

Should governments facilitate the development of 'ideal' community health centres which will offer new and better services and thus be able to build up and hold their own clienteles in

competition with the present models of practice? Or should the criteria for recognition as a community health centre be made very easy to meet so that most presently existing practices can become community health centres or parts of community health centres with very little adjustment? Can the old models be adapted and, if so, by what means?

The latter would be an adaptive co-ordinative solution, but will it work? The objectives of most presently existing practice models are entrepreneurial. It seems unrealistic to believe that the non-profit community health centre which is concerned with community development has the same goals as the entrepreneurial group practice.

Should governments try to find one all-embracing systems model, a developed type of Health Maintenance Organization model?

CO-ORDINATION AND INTEGRATION

Co-ordination is not the same as integration, says Self(5): "Co-ordination by itself cannot produce positive results unless there is a parallel movement of unifying goals and professional techniques. Enormous administrative effort is expended - rightly or wrongly - in making marginal adjustments to decisions up and down the system and maintaining at least the formal appearance of consistent action".

"... It becomes very difficult to define organization within government at all realistically or to plot the system accurately. The individual work unit (e.g. hospital or doctor's office) is buried beneath a heavy framework of organizational co-ordination.

"Administrative pluralism and integration are continually in conflict. Political forces pull both ways: financial ones favour horizontal integration, professional forces usually favour vertical integration (to strengthen specialization and career ladders) and horizontal proliferation (to emphasize the distinctive nature of the profession). There are also gropings towards more

broadly based professions - for example in physical planning, social services and health. There are formidable difficulties here. Administrative co-ordination is not the same as integrated planning although the two often seem to be confused."

However, in Canada the confusions about values, the vaguely defined objectives of government, the belief in pluralism and a range of different solutions to social problems indicates that any systems reorganization will be co-ordinative rather than integrative.

It is clear that all Canadian governments would like to have a redistribution of power between the communities they represent and the medical profession, but how best can they set about it? Governments of Canada realize very well that they must bring along the medical profession to new ways of thinking because of the pressures from consumers to change some aspects of professional and technical management of services and also pressures from other health professional groups. How fast can they go? How much must be done through formal adjustments? How much can be achieved through informal mechanisms?

Some governments, e.g. Quebec and British Columbia, are in much stronger positions than others. Quebec physicians may not wish to leave the francophone province to set up practice elsewhere and British Columbia seems to attract and hold many physician immigrants. The strategies and timing of change vary from place to place.

Governments may seek the help of local communities in decision-making if they wish to build up pressure against the medical profession and feel confident that they can push fairly rapidly towards acceptance of change.

Possibly governments are presently more concerned about legitimization of their actions with the voters than about negotiating with the medical profession. After all, emigration has dropped. Canada has become the last refuge for many doctors.

CHANGING THE PRESENT SYSTEM - WHERE TO BEGIN?

Is it better to start to make changes by setting up community health centres in parts of the system where little or no service exists already, or to make it possible for all organizations which wish to meet certain criteria to become community health centres and to give them strong incentives to do so?

"The lack of adequate primary care in the central cores of cities and in rural areas is a major deficit in today's health care system", says Steele(17). But it is not only a problem of putting in services where none now exist. Mott(18) does not think that it is wise to concentrate on developing new forms of practice only in ghettos and outlying areas. "The lack of adequate primary care is very extensive in Canada."

Few practices have social workers, public health nurses or clinical nurses practising to the extent of their skills, except for the university family practice units (which are demonstration models and have very great problems with finance), or the community clinics, which have not been able to work through their beliefs in this model to the fullest extent because of funding difficulties, and a few group practices which have moved in this direction. One of these is described by Smith(19) in a paper presented to the physicians' seminar. In it a case is made out for the professionally sponsored multi-specialty group as a community health centre model which offers an alternative form of organization to government or community sponsorship.

Thus three models are suggested.

1. The first proposal (to do something about those who have no service now) is attractive because the local population is likely to welcome a new service. Initial resistances should be fewer. But the dangers of catering only to the poor have been pointed out by Kohn and Radius(20). "Health services for the poor are poor health services." Local communities are not self sufficient, they need professional help. And New(21) has said that once they get beyond the preliminary stages in setting up a centre, the activated communities will want to control the professional helpers

in ways which were not foreseen at the time of starting the centre. In fact, the evidence shows that minority groups may be more difficult for the professionals to service because they may have accumulated resentments.

2. The second proposal is to set up a different model of practice wherever physicians would like to practice differently. This community health centre model would have:
 - (a) consumer or government sponsorship and thus community involvement;
 - (b) a team work approach.
3. The third proposal is to enable physician sponsors to provide a service better than they are able to give now, by changing the funding of group practices, so that supportive social workers, public health nurses, dietitians, etc. might be employed to assist the physicians. There might also be consumer advisory committees. Multi-specialty groups are already giving more out-patient care than solo practitioners with similar case loads and could improve hospital use patterns if this is the main purpose of changing the present system.

Klein(22) says, more choice at the local level means less satisfactory overall rational planning. But rational planning is only one-half of the answer to health care problems.

Since the objectives are multi-purpose the governments have to decide on what they really want to achieve. There appear to be three main goals:

- (a) involving consumers
- (b) developing teamwork in order to make better use of manpower
- (c) improving systems organizations.

Some problems relating to each of these will now be considered

SUMMARY

The reasons given for setting up community health centres fall into two main categories:

- (i) systematic planning to ensure better use of resources;
- (ii) pressure for redistribution of power.

Reorganization would be necessary at two levels - in the system and at the point of delivery.

What are the problems which governments wish to solve?

1. Cost Saving on Hospital In-Patient Care

- (a) incentives are in favour of filling hospital beds. Hospitals are unevenly distributed and rural populations want hospitals.
- (b) hospitals differ between urban and rural areas. Hospitals in urban areas are becoming centres of power struggles over privileges, waiting lists, etc.
- (c) although day care could be given to many people it does not pay hospitals or patient to have day care which has not got beyond the experimental stage. A supporting transport or escort service may be necessary for day-care development.
- (d) diagnostic tests are repeated, co-ordination is necessary.

. Maldistribution of skills

- (e) physicians are unevenly distributed, but because physicians are in a world market, it is not easy to get them to locate in outlying areas. Positive financial incentives do not seem to work well. The answer to distribution of medical care seems to be related to development of physicians' assistants.
- (f) too many specialists are overtrained for the work they are doing. More information is needed, more planning at many levels required if specialists are to be used better.

- (g) The have-nots are demanding more care. They want better care because of past neglects.
 - (h) Emergency rooms are inadequate to please the middle class and are not skilled enough for many other problems.
 - (i) People who move to new areas have problems.
3. Desire to maintain as much freedom of choice as possible for patients and physicians.
- (j) Although patients want free choice of physicians, there are arguments in favour of lock-ins: better budgeting, analysis of work, continuity of care and care for the inarticulate who presently find it difficult to get a doctor. Presently, the free choice policy results in lack of continuity of care, overuse by some or underuse by others. The growing demand for emergency care indicates that the present system of delivery of care is not entirely satisfactory.
4. Dealing with limitations of resources: Setting of Priorities
- (k) How should priorities be set? What should the limits of care be?

It is not known whether people would or would not be willing to spend more on health care. However, administrative procedures make it unlikely that more government money will be spent on it now. It is difficult to develop priorities within a medical care system, or even a health care system alone. These have to be considered as part of a total approach. However, attempts are being made to apply management techniques to improve health service activities.

Resistance to change is to be expected from the established groups of physicians. Popper has suggested that the values of a society can be changed more rapidly than its institutions. Those in power will defend their position. One defence mechanism will be ideology.

Change comes about through negotiation. Each government will have to develop its own pattern. It needs to be recognized that there are multiple levels of thinking - 'functional and

substantive' is one way of describing them. A sociological explanation of power and negotiation for change is given. Governments negotiate informally when they really want to change distribution of power, formally when they want to legitimate their position.

Should community health centres be developed in free competition with existing practices? Rational planning of the two systems alongside one another is unlikely to be very successful.

Co-ordination is not the same as integration. For integration, goals must be the same, also professional techniques.

Are governments presently working on problems of legitimation? The problems are ones of strategy and timing of change in relation to redistribution of power. More choice at the local level means less satisfactory overall planning but decentralization to local communities will enable governments to build up pressures against the medical profession.

Where could change begin? There are three choices:

1. Where there are no services now (but this would not be easy as it would be hard to find staff and the clientele would have accumulated resentments).
2. In a new form of organization wherever a team could be attracted and a consumer board formed to sponsor the clinic.
3. In presently established multi-specialty clinics which meet a set of criteria for becoming community health centres.

The second proposal involves recognizing consumer involvement and a teamwork approach.

The third involves teamwork and possibly consumer advisory committees.

Since the governments are attempting to achieve several objectives, it is important to consider the three main ones: consumer involvement, teamwork and systems reorganization.

REFERENCES

1. Delva, Peter: The Concept of Family Practice; The Future; Continuing Family Care.
2. Patient, Doctor, Society: a symposium of introspections. Edited by Gordon McLachlan, Nuffield Provincial Hospitals Trust. Oxford University Press, 1971.
3. Roth, F.B.: The Relationship of Hospitals to Community Health Facilities.
4. Klein, Rudolf: Resources, Priorities and Planning in the British NHS.
5. Self, Peter: Administering Democracy. New Society, pp. 389-391, Feb. 24, 1973.
6. Badgley, Robin F.: Health Centres: An International Comparison of Trends and Issues.
7. Popper, K.P.: The Open Society and its Enemies, London, Routledge, 1950.
8. Quebec: Bill 65: An Act to organize health services and social services. Official Publisher, Quebec, 1971.
9. Dubin, R: The World of Works, Prentice Hall, 1958.
10. New, P.K.: An Analysis of the Concept of Teamwork: Community Mental Health Journal. Vol. 4, pp. 326-333, 1968.
11. Selznick, Philip: TVA and The Grass Roots. University of California Press, Berkeley and Los Angeles, 1949.
12. Berne, E.: Games People Play, Grove Press, N.Y. 1964.
13. Blishen, Bernard R.: Doctors and Doctrines: The Ideology of Medical Care in Canada. University of Toronto Press, 1969.
14. Summary: Seminar: Legal Issues.
15. Perrow, C: The Analyses of Goals in Complex Organizations. American Social Review, Vol. 26, 1961.

16. Anderson, D.O.: Personal communication.
17. Steele, R.: Current Patterns of Primary Health Care Delivery.
18. Mott, F.D.: Personal Communication to Dr. Hastings.
19. Smith, N.: Ambulatory Health Care: The Views of a Clinic Physician.
20. Kohn, Robert and Radius, Susan: The United States Experience.
21. New, Peter: Community Health Centres: Five Danger Signals.
22. Klein, Rudolf.: Notes Towards a Theory of Patient Involvement.

SOME CONSTRAINTS IN DEVELOPING A SYSTEM OF CARE

GEOGRAPHICAL LIMITS

If communities are to have health centres which are to be organized into a system, it is necessary to decide what is meant by community and by health care system. It will be recalled that the concept of community is ambiguous.

One way of resolving the problem of "community" is to be quite arbitrary and to draw geo-political boundaries defining the area to be served by primary, secondary and tertiary care units. This is the solution to the problem which is proposed by Quebec. The Centre Local de Santé (or Local Health Centre) will give generalized care, the Centre Communautaire de Santé (Community Health Centre) will give specialized care and the Centre Hospitalier Universitaire (University Health Centre) will give supra-specialized care.

As Bell⁽¹⁾ points out: "Such models are attractive because precision can be attained."

Alix⁽²⁾ a planner located in Sherbrooke, assumes that it will be possible to build up social interaction between the local community and its health centre, but Anderson's study of the Eastern Ontario population's demands for health care⁽³⁾ suggests that these people have been accustomed to travelling far from their local communities.

New⁽⁴⁾ and others have described how people have been making multiple use of facilities consulting family physicians for some problems and specialists for others; going to emergency departments for what they deem to be urgencies and youth clinics/ Family planning clinics for advice about sex and reproduction.

Because of the present unlimited freedom of choice of physicians on the part of patients and freedom of choice of referral on the part of physicians, any restrictions which are imposed are likely to be strongly resisted. Setting geographical limits of choice, suggesting enrolment in practices with periods of notice to be given are not going to be welcomed. However,

there seems to be no other solution than to set some geographical limits, at least, if the health care system is to be better organized.

One suggestion based on road communications proposed by Daechsel⁽⁵⁾ for the purposes of regional hospital planning called the 'geoprobmodel' is challenged by Bell, "Neither the patient's characteristics, his need for specialized services, his economic status, nor his physician are treated as critical factors influencing his choice of hospital. They may, in some instances, have a determining influence but they are not as critical as the size and distance of the hospital".

In planning geographical limits for sub-systems within a system of health care, a series of social and economic constraints need to be considered before developing sub-system boundaries and system linkages.

SOME PROBLEMS IN SETTING UP COMMUNITY HEALTH CENTRES WITHIN A SYSTEM

Alix, Bell and Cumming⁽⁶⁾ discussed some of the problems of boundary setting which planning authorities would have to tackle.

"Within each primary centre there will be problems of:

- (a) relating to secondary and tertiary centres. Is it to be a centralized or federal system?
- (b) allocation of resources among primary centres. Do the poorest areas get the most as compensation? Or do the most active areas get the most as rewards? Or do richest areas get most in order to keep staff?
- (c) professional relationships between primary units, such as staff sharing between centres with different problems?
- (d) placing of resources between levels. Just where should the technology be?
- (e) referring rights between levels.

There will also be boundary problems between centres, and other agencies (school, welfare, etc.).

TECHNOLOGICAL CONSTRAINTS

If acute general hospitals are to be used efficiently, they should be streamlined into a system of secondary and tertiary care.

If specialists are to be used efficiently they, too, should be organized into a tiered consultancy system, and linked to hospitals where specialist technical teams can provide the support for necessary in-patient care. However, the necessity for locating these teams in hospitals should be carefully considered since they may be able to work in out-patient clinics.

Technology is not only equipment but ideas⁽⁷⁾. Consequently methods of spreading ideas effectively are vitally important. The technological ideas relevant to community care may be different from those of hospital-based specialists and community health centres may need to have a separate or distinctive centre for their dissemination.

Transportation of patients, their families, physicians and other professionals, specimens, X-rays, and other goods and services must be assessed. It is only when they have esoteric diseases that patients need to be brought long distances to doctors, and even then out-patient arrangements may be made for long-term treatment. Central supply depots may be required. Electronic equipment (computers, auto-analysers, radio-telephones etc.) may provide an information service to wide areas.

It has been suggested that to achieve greater technological efficiency the three prairie provinces should be amalgamated. However, the most efficient use of technological resources may not necessarily be best for patients.

ECONOMIC CONSTRAINTS

To allow the market to regulate the system, or even parts of the system, leaves many people uneasy.⁽⁸⁾ The rich and articulate are usually able to get more than the poor and uneducated unless government intervenes to redistribute resources

Can every Canadian expect to have unlimited rights to medical care? The technology of medical care has developed to such an extent that it would be impossible for the most advanced country to provide all the medical and dental attention demanded by its residents. How then can priorities be set within the 'political economy' model?

Field suggests that it is important to explore the inter-relationships between the qualitative and quantitative impact of biomedical technology which demands ever new capital, equipment and increasing numbers of skilled personnel and the quantitative impact of increased effective demand.⁽⁹⁾ If an increased mandate is given to either or both of these factors what will be the effect upon the total economy and the ideological resources of a nation?

Some difficult questions which remain unanswered. What are to be the objectives of the Canadian health care system - health status of Canadians or satisfaction with health care delivery patterns?

It was early on in the development of the British National Health Service that Frangcon Roberts⁽¹⁰⁾ pointed out the problem of bringing demand for health care into relationship with treatment resources. The reorganization of the separate hospitals, doctors' surgeries and public health departments into a comprehensive system with a new type of funding had greatly increased effective demand. At the same time, the growth of biomedical technology had changed the quality of the services which could be made available by health professionals and their aides. Potential demand seemed to be infinite. At the time of writing (1951) the British N.H.S. was over its first euphoric phase and was facing the realities of the high costs of medical care during a recession period. The first calculations of cost had been far too low, for the promise of 'free' health care had released a pent up demand from patients for medical, dental, optical and pharmaceutical services.

Although consultant specialists were carefully selected for hospital appointments and were known to be well qualified, general practitioners did not, in fact, know how to use the new technology of medicine developed during the war years and in the post-war period. Most of these were looked upon as the drop-outs from the medical education system and the system did little to help them to keep up to date. This reduced effective demand for technological help for many years.

After the Second World War there was an enormous expansion of funding for medical research. In the U.S. "in the period 1940-67 the funds channelled into biomedical research increased in money terms 5000%." Canada and Britain were also committed to biomedical research programs. It was a matter of national pride.

The development of new knowledge was widely shared. Specialists from all countries met at international conferences. New technical publications were developed.

In the 1960s there began to develop some concern about the application of all this new knowledge which had been accumulated. One example was dialysis and transplant in chronic renal failure. In 1967, in the U.S., the Gottschalk Committee tried to estimate the need for a chronic renal failure service. There would be 29,201 cases at minimum, 53,633 at maximum, each case costing, on the average \$71,000 to treat. In the climate of the time this did not seem unreasonable. New Regional Medical Programs were just getting into their stride and this seemed to be an appropriate addition to add to the services for cancer, heart and stroke to which they were already committed. (11a)

The reasons for starting the new regional medical programs were outlined in the Guidelines to Regional Medical Programs published in 1968: "The most significant characteristic of this research effort is the tremendous rate at which it is producing new knowledge in the medical sciences, an outpouring which only recently began and which shows no sign of decline. As a result changes in health care has been dramatic. Today there are cures where none existed before - a number of diseases have all but disappeared..." (11b)

The balloon burst soon afterwards. By 1969, Berliner (12) was saying that the delusion of American omnipotence was over:

"Some of our most basic assumptions have come under challenge; some of our most cherished ideals turn out not to be universally shared; seemingly solid support has been found more shaky than we would have believed possible...

In the past if some pressure group sought some desirable end, we could applaud and encourage even if it were not quite 'our own thing'. Today we, must make unwanted comparisons. Pressures of this sort carry with them a danger; somewhere along the line someone will have to set priorities among desirable goals; and a high enough priority for one may mean the end of another. This is not necessarily wrong, but it represents a new hazard, and it behooves us to try to see that the ordering of priorities is appropriate.

Ultimately the setting of priorities depends upon the wisdom and values of those in positions of responsibility, as well as the popular support of one or another course, and most importantly on the clarity with which issues are understood by both the public and decision-makers."

The Regional Medical Program funds were reduced.

Canada is presently reviewing its research in terms of priorities, the Lamontagne Committee⁽¹³⁾ suggests that there is need to move away from research in life sciences to research in social sciences.

SOCIAL CONSTRAINTS

There is a population base which has its own ideas about community. To recapitulate Bell's list (Chap.3):

- (i) There are natural territorial boundaries.
- (ii) There are administrative boundaries with historical meaning and political implications.
- (iii) There are social-psychological boundaries. There are entities of shared feelings and shared interests. Some of these entities are very strong,

some formal such as professional groups or political parties, some informal such as college classmates.

- (iv) There are social-structural boundaries - sets of relationships and institutions-social arrangements which can easily be recognized.
- (v) There is an information environment dependent upon communication networks.

FINDING A BALANCE: REGIONALIZATION

The balance between technological efficiency and community self-consciousness is liable to change with changing technology (i.e. transportation, computer services) and it is important to discover what the right balance is at any one time. Saskatchewan's regions are now too small for technological efficiency. But to suggest the amalgamation of health programs in the three prairie provinces or the Maritimes is bound to offend local sentiment.

The concept of "regionalization" seems to be a central concept in many discussions of Community Health Centres because the region is seen as the organizing authority which puts individual centres into a system. Yet there are almost no data on the subject of regional systems to guide thinking.

The term "regionalization" is ill-defined. The Quebec system was explained in detail in Chapter 10. A region in Quebec is a geographical district of a least 5,000 population, which has primary, secondary and tertiary care centres and is based on one or more medical schools.

P.E.I. (100,000 population) is discussing whether to divide into regions. British Columbia's 28 regions cover vast territories but are not self-sufficient entities (in the Quebec definition of region) because there is only one teaching hospital group in the Province to which tertiary referrals may be sent.

Need a region have a teaching hospital at its centre? Or are there other more important considerations?

Anderson⁽¹⁴⁾ sees a need for health authorities to link all health care activity in remote rural regions. He points

out that this is the way in which rural Scotland is trying to solve problems of health care. Regional officers plan and organize clinics as satellites. There may also be a cause to be made out for the development of regional health authorities in urban areas to work closely with urban planners. There seem to be as many semantic problems with the word 'region' as there are with 'community'.

One begins to wonder whether, in Canada, provinces are regions in the sense necessary for technical organization and that the so-called 'regions' are what are called areas or districts elsewhere.

Following on the Task Force recommendations that there should be developments in regionalization, Meekison⁽¹⁵⁾ has made a study of the concept in B.C. His findings have not yet been published but he has discovered that:

- (a) There was no real interest at the provincial level in delegating power to regions (c.f. the Castonguay Report and Law 48 in which there was some withdrawal from commitment to regionalization).
- (b) There was no real interest in rural B.C. at consumer level - consumers in general were happy with the services they have. They are prepared to travel to the doctors they want to see. They are not even very interested in developing complaints machinery.

It is Meekison's considered opinion that for the presently defined regions to work, there would have to be massive educational programs for provincial politicians and officials and for consumers; and there would need to be adequate financing of regions.

Roth(16) is pessimistic about the development of effective regional machinery. He has said that the philosophy of decentralized and pluralistic power system in Canada is likely to prevent the emergence of such a system at a level intermediate between province and locality.

CENTRALIZATION VS. DECENTRALIZATION: REGIONAL POWERS FOR RATIONAL PLANNING

Because health care planning is part of general social planning, it does not seem likely to succeed unless it is tied into the sources of power. These sources of power are presently dispersed -- there are still numerous funding mechanisms and many different levels of organization which have a say in distribution of services. Contracting organizations such as hospitals and the health professionals themselves have been very conscious of their power to give or withhold services and advice and have maintained a good deal of control.

Because power is dispersed, the 'political economy' of health care is subject to many pushes and pulls. The 'market economy' no longer operates properly and there is no systematization of the developing power structures. It seems quite likely that previous attempts at regionalization came too early in the development of Canadian health care. In Saskatchewan, in 1944, the Sigerist Report proposed regionalization and health centre development, but the plans were undermined by the federal cost-sharing programs which led to different patterns of co-ordination, vertical not horizontal. Since then much has changed.

Rubber stamp regional boards would be a waste of everyone's time. Unnecessary intervention would be worse.

The provinces will need to reconsider what can be delegated downwards to local communities and what needs to be pulled together into one system instead of being loosely connected, poorly organized and haphazard.

To recapitulate Selznick's argument⁽¹⁷⁾, it may be necessary to maintain relations between power groups which, however consequential, are informal and covert. If adjustment to specific nucleuses of power becomes public then the legitimacy of the formal authority may become undermined. It may be, then, that regional machinery should be concerned with legitimation: publicizing and popularizing ideas rather than negotiation with power groups.

In Canada, new regional authorities could be conceived as agents drawing together the presently dispersed units which make up the system (solo practices, groups, hospitals, public

health departments) into a better organized whole. In order to do so, they would have to work to guidelines from the provinces but their function would be twofold, acting as agents of the province:

- (a) to plan and authorize the development of new services,
- (b) to control, through budgets and evaluative techniques, already existing services.

Provincial governments would have to be prepared to delegate funds for redistribution to the health care institutions in their area and to allow them to develop a secretariat, and possibly consultancy, evaluation and other important services.

However, it is at provincial level that most decision-making about such matters as union agreements, licensing etc. will continue to be made, so regions will have limited powers of negotiation.

Glaser(18) speaks only of negotiation between government and the medical professional associations, but other important groups which should be considered as provincial bargainers are emerging.

The case was made out that group practices should have their own bargaining machinery with government(19). Some have, in fact, managed to get separate treatment (e.g. the St. Catharines and the Sault clinics and, very recently, Reach in Vancouver and the Saskatchewan clinics but this is most unusual. All group practices complain that the scales are weighed against groups, particularly in relation to start-up costs. Like all good managers, the clinic administrators are concerned to diminish the uncertainties of their organizations. They believe that properly organized negotiating machinery would be very helpful to them in this regard, they could begin to plan more confidently after formal agreements.

The systems of accountability, developed in the past when voluntary organizations relied on donations and subscriptions, have been challenged, particularly by consumers who are not satisfied with the managers' accounting to Boards which seem to them to be too narrowly constituted, not well enough informed about real issues and no longer the responsible authorities.

There appears to be considerable need to re-examine problems of the accountability⁽²⁰⁾ of voluntary organizations in Canada which do not now raise their own funds except in a very minor way, but depend for 90% or more of their income on redistributed tax funds.

The appointment of expert provincial technical advisers might be a useful addition to the scene, but much would depend upon the way in which they gave advice to the community health centres and other local health care institutions. Their main contribution will be their breadth of experience which enables them to see the place of the agency in the total picture.

In the U.K., attention has been given to the most appropriate levels for locating consultancy services in community health care - architects and engineers are located at national and regional levels. By publishing building notes and design guides⁽²¹⁾ and issuing circulars from the central department, it is hoped to influence the thinking of local architects and engineers in building economical and well-designed premises for the delivery of health care, and to influence patterns of work of the health professionals employed in the centres. Operational research and work study officers are at regional offices.

It is clear that in the U.S., a regionalized system is also seen to be a large step towards rationalization. In general the provision of services up till now has been haphazard and in many places, ineffective. Thus, for example, the Background for Planning 1970 (of the Los Angeles region)⁽²²⁾ is an inventory of resources and activities in the area, the first step towards co-ordination.

OTHER FUNCTIONS OF REGIONS: EDUCATION OF CONSUMERS, COMMUNITY DEVELOPMENT

One question which arises is whether the population needs any new representatives to be specially concerned with health matters over and above those democratically elected to provincial and municipal governments, bodies which already exist in law and have a tax base. It will be recalled that the Second Manpower Conference recommended the establishment of advisory National and Provincial Health Councils⁽²³⁾. Should this concept of advisory councils be taken further down the system right to the level of the individual health centre? And how would a new system

of Regional Councils be tied into District Boards and Health Councils?

Warner⁽²⁴⁾ makes out a case for the introduction of new health authorities at a variety of levels.

He cites some experience in the U.S. which has decided to develop regional health boards following the passing of the Partnership for Health (Public Law 89-749). This law specifies a mix: a majority of consumers, together with providers of health services and local elected officials working in concert. Warner quotes a report by Graves⁽²⁵⁾ "The structuring of the citizens' health council members was viewed in the context of a political process. The council's effectiveness, it was thought, could be strengthened and its decisions more widely accepted if its membership had a broad base of community support. Input and feedback beyond the citizens' health council members was considered essential. Various alternate methods of consumer selection were considered; election and appointment by elected officials or selection by random sample, for example. But, because it was felt that selection of representatives should be determined as much as possible by the community, formation of health committees from various political jurisdictions was considered. Providers would have organizational strength; so, too, should consumers."

It would seem, from reports of observers, however, that the regional committees in the U.S. are still at a very early stage of development, and have a somewhat uncertain future. Is this because these particular committees have no resources of their own and thus no real power to redistribute? Graves goes on to describe the "representative" group on a U.S. Regional Health Council which includes people both from within and outside the labour force. The former includes professional, technical, managerial, clerical and sales, skilled and semi-skilled, under-employed labour and service-trade people; the latter, housewives, parents, welfare recipients, groups under 21, and senior citizens. Further refinements were made to obtain representation from both coloured and white. Educational content formed the core of the early orientation meetings. Problems were discussed which included definition of terms, the ratio of physicians to population in various localities, the meaning of group practice payment, location and utilization of health facilities. "The accent was upon a learning process and a

study of the dynamics which were to allow the group either to operate or which would doom it to failure".

Warner compares this learning with his experience in developing a lay advisory group to the Vancouver branch of the College of Family Physicians. "This group discovered that if it were to discuss general problems of health care delivery, then it had first to discuss particular instances before it was able to generalize and look at the total pattern. In this instance, education came from personal experience. The information-education function is one which cannot be overstressed if consumers are to act on a rational basis and in an informed manner."

THE FUNCTIONS OF REGIONAL BOARDS MUST BE CLEARLY DEFINED

Regional Hospital Boards have usually been less concerned with technical efficiency of the health service than their local constituents' business interests. Many board members of voluntary organizations are very confused about how they should function. They need to become aware of the fact that their Board is no longer independent but form part of a total system, that their responsibilities have changed and that they are now accountable not only to their immediate supporters but also to the citizens of the province for the service which they are providing. This change of attitude will not come about overnight. The importance of clear definition of board members' roles and objectives and the need for training to understand them was brought out by Haughton(26) in the seminar on consumer involvement.

In Britain, new health authorities are being developed at the so-called area level. These are less concerned with education of the consumer and more with improved co-ordination of services. Consumer representatives on the Boards will be advisory to the full-time Board members who are to be government appointed officers. The Conservative government presently in power has made it quite clear that it will not tolerate confusion on this point.

The present Minister(27) has said, "It is also important to have more effective representational mechanisms by which local attitudes can be known and safeguards built in. But it would not be right to incorporate these mechanisms in the management structures." The Minister was anxious to avoid

"a dangerous confusion between management on the one hand and the community's reaction to management on the other".

Should consumers' representatives expect to be brought onto the Boards of organizations without either having a personal financial stake or being elected by the public? If so, this would change the whole established system of Board ability as it has developed in law.

The importance of knowing one's role as a Board member was discussed at great length by British politicians during the thirties and forties when many of the country's basic industries were being nationalized. Trade Unionists were persuaded that Worker-Directors could not function properly. It was better to have governing boards and a trade union opposition without whose general consent the organization could not operate. The same principle is being applied in Britain to consumer involvement. They are to be advisors, not managers. The issue may not be quite parallel in industrial and social service organizations for as Warner points out, consumers are ill-informed certainly so in comparison with trade union opposition groups. Thus different machinery may possibly have to be developed for consumers of services.

Although Canadian politicians are having to make more decisions about priorities in spending and are forcing public debates in the press, are the provinces going to be willing to delegate real decision-making power downwards to regions, to districts, to communities and particularly to clinics per se? Given the problems of rationalization of the technical system which need to be solved, are we ready for this delegation?

It would appear that effective regional boards might be made to work if they were given adequate terms of reference, decision-making powers and budgets. Alternatively, regional advisory committees might be set up in order to improve understanding of public opinion. But past experience warns that voluntary regional councils have not been very useful bodies. They did not focus upon their purpose of advising about regional health care.

The question of centralization-decentralization to regions or districts is a complex one. It may be possible to centralize a number of technical decisions and to decentralize a number of social decisions as industrial management has been learning to do in the past 30 years since participant bureaucracy has been in vogue.

HORIZONTAL INTEGRATION

The bringing together of health and welfare services was discussed in Clarkson's⁽²⁸⁾ and McKinnon's⁽²⁹⁾ papers. The seminar group which discussed these papers⁽³⁰⁾ seemed to accept that there were some cogent reasons for bringing together provincial health and welfare departments at the ministerial level. Equally, there were other arguments for keeping them apart; the main objections in principle being medical dominance, and too great centralization of the large health and welfare budget into one large Provincial government department. The operational difficulties were mainly managerial - getting the professions to work together was not simple. As well, experiences of co-ordination in the past had been fairly limited, related only to attempts to link salaried health and welfare workers. These experiences might not be a useful guide to the problems which could arise in trying to bring independent entrepreneurs, voluntary associations and salaried workers into one system.

The difficulties of bringing together health and welfare services at provincial, let alone regional or local, levels are formidable when the federal government seems determined to maintain separation between shared cost programs for health and for welfare. Unless more of the provinces ask for non-tied grants as Quebec has done so that decisions can be made at provincial levels about redistribution of tax moneys to those whom the province regards as most needing to be employed or subsidized, these difficulties of integration will continue. It would seem that Alberta as well as Quebec is beginning to question the present federal policy.

SUMMARY

Constraints on boundaries of 'community' were explained in the chapter on definitions. Geographical models of primary, secondary and tertiary centres are attractive because precision can be attained. But it may be difficult to organize care into small geographical units because Canadian patients have become accustomed to travelling for their care; also professional referral patterns are not streamlined.

If rationalization is to proceed, there seems to be no alternative but setting limited geo-political boundaries; yet these will be difficult to establish because people have got used to travelling far and wide in search of doctors when it suits them. The boundaries chosen must recognize and balance technical and social constraints. Within primary care centres the following boundaries will be important:

- (i) relationship to secondary and tertiary centres - a centralized or federal system?
- (ii) which areas will get more - the poorest, the more active, the richest?
- (iii) will centres share staff?
- (iv) at what levels should resources be placed?
- (v) referrals between levels need to be considered in planning for change.
- (vi) relations between health centres and other welfare agencies need to be sorted out.

The most efficient technological use of resources may not necessarily be the best use for patients. The balance between technical and social constraints changes over time.

To allow the market to regulate the system leaves many people uneasy. The rich and articulate are usually able to get more. How, then, can priorities be set? What are to be the objectives of the Canadian health care system?

There has been a change in attitude to the use of biomedical technology since the war and developing a system of priorities has been emphasized since 1967. Ultimately the setting of priorities depends on the wisdom and values of those with responsibility.

Regionalization has been proposed as the solution to problems but regionalization is ill-defined. It is a word which varies in use from one province to another. Regionalization may be necessary for rural satellite development and for urban planning.

Are "regions" in Canada the same as "areas and districts" elsewhere? Are provinces "regions"? Meekison found little interest in regionalization in B.C. The province did not want to delegate down, consumers were not interested in regionalization. For regionalization to succeed there would be need for education of producers and consumers and adequate financing of regions.

Planning would have to be tied into sources of power but power is still dispersed as the "political economy" model of health is not yet established. Can effective regional machinery be developed? Has the situation changed since earlier failures? There is need for more rational planning of services on a regional basis.

Regional authorities might be regional boards with powers to plan, budget, etc., or perhaps they could educate consumers who need to have more experience in thinking about problems of health care before they can make an effective contribution.

Are provinces really going to delegate power to regions and boards? If not, are advisory bodies likely to work? Past experience is not encouraging. Voluntary regional boards did not focus on health objectives. There is great confusion about purposes.

The bringing together of health and welfare services is hindered by federal cost sharing programs. Only Quebec has opted out of the tied grant system but Alberta is also beginning to question its implications. With the present system, the provinces cannot decide who best to employ or subsidize in redistributing tax moneys. The prospects for delegation to regional or local level are not obvious within this constraint.

REFERENCES

1. Bell, Norman: Some Thoughts on the Community in Community Health Centres.
2. Alix, Jean-Pierre: Problèmes de Définition et d'Adaptation. Le Centre Local de Santé.
3. Anderson, R.M. et al: The role of the Medical Faculty in reorganizing Family Practice to meet Current Community Needs. Can. Med. Assoc. J., 103, pp. 589-593, Sept.26, 1970.
4. New, Peter K.: The Relationship of Emergency Services and Community Health Centres: One Perspective.
5. Daechsel, W.: Regional health care planning. Ph.D. Thesis, Columbia Univ., N.Y.C., 1971.
6. Notes on a meeting with Alix, J.P., Bell, N. and Cumming, E., November, 1971.
7. Dubrin, R.: The World of Work: Prentice Hall, 1968.
8. Tsalikis, G.: The Patient's Freedom of Choice and the Community Health Centres.
9. Inkeles, Alex and Barber, Bernard: Stability and Change in Social Systems: Little, Brown, 1971, p. 30-60, Stability and Change in the Medical System in ed.
10. Roberts, Frangcon: The Cost of Health, Turnstile, 1952.
- 11a. U.S. Department of Health Education and Welfare: Health Services and Mental Health Administration. Guidelines to Regional Medical Programs. Rockville Md. 1968.
- 11b. U.S.A. Bureau of the Budget: Report of the Committee on Chronic Kidney Disease, (Gottschalk Committee) mimeographed, Washington, D.C. 1967.
12. Berliner, Robert W.: The Relevance of Medical Science to Medical Care: Presidential Address. American Society of Nephrology, mimeographed, 1969.

13. Canada Report of the Senate Special Committee on Science Policy. Vol.1 - A Critical Review: Past and Present, Vol.2 - Targets and Strategies for the Seventies, January 1972, Government Printing Bureau, Ottawa, 1970,1972.
- 4a. Anderson, D.O.: Personal communication.
- 4b. MacGregor, I.M.: mimeographed paper, Scottish Home and Health Dept. Health Services in Rural Scotland. December 3, 1971.
- 4c. Brotherston, J.H.F.: Public Health Objectives - The Impact of Social and Technical Change. Fourth Thomas Parran lecture, School of Public Health, University of Pittsburg, Pittsburg, Pennsylvania, Feb. 14, 1967.
15. Meekison, W.C.: Personal communication.
16. Roth, F.B.: The Relationship of Hospitals to Community Health Facilities.
17. Selznick, Philip: TVA and The Grass Roots. University of California Press, Berkeley and Los Angeles, 1949.
18. Glaser, William A.: Paying the Doctor. The Johns Hopkins Press, Baltimore and London, 1970.
19. Crichton, A.: Summary; Seminar on Business Management.
20. Crichton, A.: Care for the Emotionally Disturbed Child, Canadian Welfare Vol. 48, Jan.-Feb. 1972, p. 14.
21. Health Centres - A Design Guide. Great Britain: Department of Health and Social Security and Welsh Office: Her Majesty's Stationery Office, London, 1971.
22. Los Angeles Region, Welfare Planning Council: Background for Planning, 1970 ed. Research Report No.22, Vol.1 Census Use Study Southern California Regional Information Study, October, 1971.
23. Canada Department of National Health and Welfare: Report of the 2nd National Conference on Health Manpower, Ottawa, 1972.
4. Warner, M.: Consumer Education and Re-Education and New Forms of Health Care Delivery.

25. Graves, John G.: Area-wide Planning: Involvement of Consumers. J.A.H.A. Vol.44, October 1, 1970, p.46-50.
26. Haughton, James G.: Citizen Involvement in Health Affairs.
27. Great Britain, Department of Health and Social Security; National Health Service Reorganization Consultative Document, May 1971.
28. Clarkson, Graham, J.: Difficulties and Advantages in the Amalgamation of Health and Welfare Services.
29. MacKinnon, F.R.: Social service delivery systems.
30. Morgan, J.: Summary: Seminar: Social Services.

LINKING COMMUNITY HEALTH CENTRES INTO A SYSTEM

OBJECTIVES OF CHANGING THE SYSTEM

The differing goals of governments have been discussed. Some are more interested in streamlining a wasteful system, whilst others are more interested in developing community health centres to act as a nucleus of community development and social services linkage. At provincial and regional levels, these two objectives can be combined without too much difficulty. It is at the local level that the true problems emerge.

If community health centres are conceived as contributing to an entrepreneurial system, as gap-fillers for underserved areas and equal competitors offering a different kind of health care where a service already exists, then governments will be interested in changing the payment systems only so far as they will meet these objectives.

If the provinces are interested in 'welfare state' or community development objectives, community health centres will be developed in a separate system alongside the private system. The concessions given to the private system will be those which must be given in order to maintain a service but community health centres can expect to have favoured treatment.

SPONSORSHIP

"The sponsor of an ambulatory care unit may be one or more physicians, a consumer organization, a union, a business organization, a community group, a hospital, a medical school, a local medical society, or the government" says Blackman⁽¹⁾.

"Sponsorship has a predetermining effect on many of the structural elements which are decided at the same time.

"In deciding upon the form of the various structural elements comprising an ambulatory care unit, the identity of the sponsor (and thus the composition of the Board) is of critical importance... However, most programs are not unilaterally controlled by the sponsor and its Board of Trustees."

The sponsor, says Blackman, will, of course, weigh his own interests more heavily but will also have to pay attention to external factors such as the local medical-legal organization, state of health resources, attitudes of patients and physicians and the health state of the community. The attitudes of consumers, particularly will affect decisions about the use of ancillaries, the primary contact mechanism, locus of practice and the identification of patients with specific physicians. "Imposing a given delivery model on patients who are unwilling to use that model will result in patient dissatisfaction or underutilization... Likewise... if a model is constructed which is not amenable to physicians, the ambulatory care unit will either have a difficult time recruiting physicians to work in the unit or the physicians it does recruit will not practice according to the model. (There must be) physician willingness to accept the scope of practice, locus of practice, relationship to hospital, relationship of the physician to the organization, method of physician compensation, use of ancillaries and hours of service prescribed.

"Sponsorship's primary influence occurs during the decision making operations of the ambulatory care unit rather than during the delivery operations...

"Sponsorship has little effect on (day-to-day) economic performance since it does not directly affect delivery of service*... but it may have some direct administrative or publicity costs...

Sponsors are unable to exert an influence upon day-to-day operational activities of group practices and community health centres because their positional authority, though overtly great, is overwhelmed by the operational decision-making powers possessed by the administrators and physicians."

One administrator saw the function of the sponsors and the business manager in a community health centre as shifting some of the power away from the doctors towards the community to meet patients' needs rather than maximizing income for doctors.

* Chase ⁽⁴⁾ made an important point when he said that a clinic manager should work on organizational problems before the start of practice.

INCENTIVES TO REORGANIZATION

All provinces have in common the desire to get better value for money. In order to do so, the present incentive system, which encourages hospital use, will have to be changed.

But although all the provinces want better value for money they are not agreed on the best means of saving money. It seems clear, however, that the first step should be to link hospitals and doctors' offices into one budgetary system.

If doctors were to be rewarded for keeping patients out of hospital instead of rewarded for admitting them, they might reconsider their present disposition of their clientele.

Evans⁽³⁾ was asked to review the interrelationship of community health centre and hospital costs for the Project. He concluded: "Substitution, rather than accretion is the only way to increase efficiency... And, if people are to behave differently, it is not sufficient that their institutional environment be changed. The pattern and direction of incentives must also change. Thus excess utilization of hospitals and other treatment facilities will not disappear if physicians are encouraged to move into new sorts of buildings. They must also be relieved of the excess output pressures embodied in present fee-for-service modes of payment.

"A community health centre program which continues to pay physicians on a fee-for-service basis and merely adds to the national stock of ambulatory treatment facilities will probably reduce hospital costs by about 1 - 3%, if at all, on a net basis. (That is, after allowing for treatment costs in community health centres of patients who would have been in-patients). On the other hand, a community health centre program which both modifies physician incentives and promotes home care alternatives to hospitalization could have a more substantial effect. A very rough estimate suggests 10 - 15% on a short run basis and 15 - 20% after the total hospital stock has had time to adjust. Against this must be set the (unknown) costs of home care alternatives, both to the patient and to the community health centres. But 20% of the nation's hospital bill is now more than \$400 million, which would buy a lot of home visitors. And in any case, a substantial part of the reduced hospital load would be expected to be made up of unnecessary treatments which were simply eliminated, and so imposed no additional costs on anyone."

1. LINKING DOCTORS' OFFICES AND HOSPITALS

The Health Maintenance Organization system should be considered⁽⁵⁾. In this model, the centre is paid on a capitation basis for looking after the patients in all parts of the system. Doctors' offices and hospitals are linked financially and the physicians are given incentive payments for keeping patients out of hospital. Hospital services are pared to the minimum. This system has its critics. In the United States, patients who enrolled in the Kaiser Permanente program (which is usually cited as the model) choose this for 'best buy' reasons rather than other more expensive programs. There have been some questions about the implications of this model for the care of chronic or geriatric patients who need more attention and possibly more institutional treatment and weightings to take these patients' needs into account would have to be considered.

2. LINKING DOCTORS' OFFICES, HOSPITALS AND COMMUNITY CARE

Logan⁽⁶⁾ says: "I would feel that the community health centre alone is not adequate in itself to reduce the provision of acute hospital beds... Canada would have to take on the other ambulatory services."

Presently physicians tend not to think about referring to social workers, public health nurses, etc. Rein⁽⁷⁾ has pointed out that even in Britain where there are well-developed community care services and no economic incentives to refer to specialists, primary physicians still do so. He thinks that they find it safer to have a second physician's opinion. It diminishes their personal accountability. He would agree with Logan that "Economic devices are seldom the solution to health care problems because the public and the professionals will find ways of manipulating them." Logan is fairly sceptical of financial incentives and suggests exploring evaluation and consultancy for ambulatory care physicians (i.e. reviews of work done by physicians on a selected day).

3. INCENTIVE REIMBURSEMENT SCHEMES FOR GROUP PRACTICES

Incentive reimbursement systems are being tried in hospitals. These systems might also be applied to group

practices. Hardwick and Wolfe(8) have described three systems which were developed in the U.S but these have been criticized by Rafferty(9). In his paper, Rafferty emphasizes that the ultimate effects of incentive reimbursement systems will depend upon the degree in which case mix variations occur and the degree to which the target setting formulae identify these variations. Anderson(10) writes, "Group practices differ from hospitals. We must also consider the multi-product nature of the activities of group practice. These are exceedingly difficult issues and it is obvious to me that there is both no literature on the subject and the crucial data to evaluate the incentives does not exist. I have reviewed various research projects that have been funded by the National Centre for Health Services Research and Development in the U.S. and have found none in this field whatever or even remotely connected to this field."*

4. GLOBAL BUDGETING (BASED ON CAPITATION OR PAST EXPERIENCE)

Global budgeting is now being tried out in the community clinics in Saskatchewan following the Anderson/Crichton study(11). The budget is based on clinic revenues in previous years. Presently, in Canada global budgeting has had to be limited to hospitals or specially selected clinics which are designated as hospitals or those which have reached agreements on capitation instead of fee-for-service (e.g. St. Catharines and Sault Ste. Marie), because of cost-sharing legislation.

Clearly, a change in federal provincial cost-sharing arrangements would be necessary to alter these present artificial administrative boundaries and free the system. One community health centre project committee member who had experience of handling a global budget in a hospital said that before global budgeting became general more agreed rules

Dr. Anderson suggested that Dr. R. Carlson, Director, Special Operations, Bureau of Health Insurance, Baltimore, Md., should be consulted about incentive reimbursement schemes. He wrote to the Project Research Coordinator and cited a number of Medicare programs which were being evaluated, none of which had yet been demonstrated as viable.

about the use of savings needed to be set down for, with changes in governments and health department officials, the efforts of staff to make savings within these total budgets could easily be underrated, confidence could be undermined and incentives to save discouraged because of feelings of distrust about government intentions.

Global budgeting is a method which has been used in British hospitals since 1948. It was the advantage that government accounting procedures are simplified, but the disadvantage that units with low standards and poor administrators never seem to be able to pull themselves up to the level of the well-organized institutions.

5. SATELLITE CENTRES

Since many rural health workers are isolated and need backing up, and other individuals such as pharmacists want to be brought into a common network of care, a policy of giving incentives to groups or individuals to work together might be developed. Satellite attachments to recognized centres could be encouraged.

6. NEW AREAS

Perhaps special incentives should be given to centres starting up in areas where no centres exist now. There was a good deal of discussion in seminars on problems of capital costs and start-up costs. Perhaps badly located physicians should be helped to move by purchase of their investment?

7. INNOVATIVE CENTRES (NEW SERVICES)

Possibly incentives should be given to sponsors wishing to develop experimental forms of health care delivery.

DISINCENTIVES TO ENCOURAGE REORGANIZATION

Disincentives to sponsors might be developed by applying tighter administrative controls:

- (a) over surgical privileges
- (b) over the location and use of specialists in primary care. This would diminish overservicing, waste of skills and might help the system to move towards a better primary, secondary and tertiary care organization. (Limitation of admission to specialist training programs, by agreement between governments, Royal College and universities, would have to be considered, if a program of redeployment were to be contemplated.)

INCENTIVES TO PATIENTS TO USE SERVICES BETTER

Should patients be given incentives to lock themselves and their families into a practice, to enrol for continuing care, to use one doctor and his group or his referrals exclusively? What might these incentives be? Free checkups? Reduced premiums or taxes? This should be given some consideration in addition to an alternative which was suggested by Detwiller⁽¹²⁾ that patients should have the possibility of buying additional services. Perhaps governments could specify additional services which could be made available without charge to enrolled patients such as reduced drug costs, some dental care, free private rooms when necessary to be hospitalized, etc.

ONE KIND OF SPONSORSHIP RATHER THAN ANOTHER

The incentives discussed above are intended to link one part of the system to another. A different kind of incentive scheme should be considered if it is thought to be useful to reward one type of sponsor over another.

Claims were put forward by several different forms of primary care delivery organizations that they could provide a better service than others.

1. Hospitals claimed that they had the skilled administrators and premises would become available. The hospital administrators thought that hospital emergency rooms could be developed into outreach clinics.⁽¹³⁾ They discussed this development as a solution to the problem of making use of

presently existing hospitals. They favoured the legitimation and extension of out-patient services given in hospitals, for hospitals were prepared to give a 24-hour service and they had to be kept open as part of a 'disaster plan'. "The physicians would be satisfied, the consumer would have additional services, the administration would be enlarged, the boards would have a larger market to service."

But this solution was challenged: "The concept of the hospital in reality being the symbol to meet the health needs was in effect an organization chart solution." It would meet doctors' needs but not necessarily patients' needs. "While hospitals had a high degree of acceptability, particularly in a crisis situation, the concept of hospitals acting for the total population as a source of health care delivery was challenged."

Are outreach clinics an exercise in empire building or would this be a useful development? The pros and cons are discussed by Babson et al.:⁽¹⁴⁾ "The strength of the proposal lies in the ability to apply the technical and organizational skills of the hospitals to ambulatory care centres; the weakness includes perpetuation of in-patient primacy, the difficulties in dividing cities up into hospital service areas (not a major problem) and the failure to recognize that ambulatory care relationships ought to be primarily with the community and with other social services rather than a hospital. There is, of course, the possibility that decentralized hospital clinics in the community would be fully responsive to consumer wishes and broadly integrated with community services."

2. Smith⁽¹⁵⁾ claimed that multi-specialty group practice was already giving a health centre service and that patients were satisfied. Smith's clinic combines primary, secondary and tertiary ambulatory care under one roof. The advantages of so doing have also been argued by the physicians at the Saskatoon Community Clinic, who believe that the continuing interaction of generalists and specialists is advantageous for both. At the business managers' seminar⁽¹⁶⁾, the manager of a physician-sponsored clinic in Winnipeg said that a consumer advisory committee was being set up in his organization.
3. Should community health centres which are non-profit making for physicians be encouraged more than profit-making physician-sponsored centres? Does the non-profit aspect of

organization have any implications? Possibly this is an irrelevant issue in partnerships and groups in great insecurity.

4. There is also the question of profit-sharing. It has been pointed out to the Project that both patients and physicians could profit from a well-organized clinic offering less expensive additional services which are now normally paid for, e.g. prescription costs could be cut for patients while still providing a profit for clinic sponsors.(17)

Differences between hospital outreach, multi-specialty practice and community health centres are discussed in the following chapter.

INCENTIVES TO INDIVIDUALS WORKING IN COMMUNITY HEALTH CENTRES

This subject is so closely related to the development of teamwork and community involvement that it will be considered with those concepts. (Chapters 17 and 18)

PROFESSIONAL COMMUNICATION AND EDUCATION

The question of hospital privileges and the physician's view of the hospital as the centre of the communications network has already been discussed.

Logan(6) emphasizes the importance of the relationship between general practitioners and hospitals and what he regards as the unfortunate separation of the British general practitioner from the hospital. He wants all practicing physicians to have hospital privileges. But Anderson(10) says: "I think we should really take a very close look at the degree to which physicians should follow the patient from the office into the hospital as opposed to hospital physicians going out into community health centres. Community health centres themselves should become ambulatory care units on the academic model with rounds, excellent medical records, peer review, etc... Hospitals are becoming closed to all but specialists". (It is the claim of the multi-specialist clinics that they are working in this way).

If physicians are to be discouraged from viewing the hospital as the centre of their professional and social network what can be put in its place? How can their needs for formal and informal social interaction be met? What arrangements for continuing education can be organized which will hasten the evolution of more community centred care? How can their continuing education be paid for?

The community clinics in Saskatchewan, which had difficulties in relating to the local hospitals, have tried to develop their multi-specialty groups into a fairly self-sufficient organization. Not only do they have regular peer-review sessions within the clinics, but they meet as a provincial group either privately or in public session with well-known international speakers from time to time. In these meetings they focus upon health care delivery problems rather than clinical discussions, but both are necessary.

These pioneer organizations felt isolated and ostracized and determined to survive and flourish to show the international medical profession that they had a message about good practice.

In Ontario, the Mustard Report(18) published in the spring of 1972, suggests the need for organizing satellite continuing education centres attached to universities for physicians out in the community.

The shift to a new centre of involvement for community physicians may be one of the most important functions that a systematization of services will achieve.

Discussing frustration among British general practitioners and comparing it with U.S. experience, Mechanic(19) says "for the most part the education was all of the same character - it emphasized the hospital practice of medicine in contrast to social and preventive aspects of medicine. Although many of the doctors had bed access and hospital appointments, it was clear that they did not feel welcome as equal participants in hospital contexts. The general practitioner, if he is to be successful, must have a social and preventive orientation as well as a technical one and he must be able to obtain gratification from situations where he deals with people in circumstances of great uncertainty and where basic knowledge is frequently absent... Many medical students have entrepreneurial orientations and strong scientific-technical perspectives. Moreover, there are

strong biases among medical schools toward selecting students with background in the 'hard' rather than the behavioural sciences and there is a large over-representation of students from higher socioeconomic groups."

One new form of organization to correct the bias towards too great emphasis on medical specialist expertise is the health sciences concept. This concept is not yet well developed in relation to community medicine. One of the problems has been the funding of new student training centres - the new family practice units. An important part of systems linkage must be concerned with the funding of students' education in these new approaches to community medicine. Training costs should not be borne by the centre itself where students are placed, but by the region or province.

Larsen(20) discusses the development of the health sciences centre concept of health professionals' education: "There has been a departure from the common practice of each group making (educational) plans in isolation from one another" a departure which has come about as a result of the nurses' desire to have new roles in community medicine. "An attempt is being made to identify the functions of the role prior to planning educational objectives and programs for the role."

Larsen, describing this approach to professional education of personnel for primary health care, uses a model which is concerned first to specify behavioural objectives, then to develop learning experiences using continuing evaluation. Thus, he says, it is important to discover more about the activities actually to be performed in order to make the preparation relevant. "If scarce resources are to be used efficiently in the training as well as the employment of health personnel, it is important that the responsibilities of each occupational group be defined so that they are complementary, interdependent and relatively non-overlapping." The educational process should be concerned not only with medical care but with orientation to the health team and with a broad approach to learning which should maintain the desire to continue with self-education and facilitate career mobility.

Larsen appears to be hopeful of the success of this approach, though there have been considerable difficulties in getting joint classes in the university setting. It is not in classwork but in field work or other practical situations that

the health team comes to life. All of the disciplines have hesitated to commit themselves wholeheartedly to the concept. Some of the other schools may fear that they will be dominated by the powerful medical schools; social work may fear being made to fit into the medical model. Much has still to be worked out.

As far as continuing education for community health care is concerned Hall⁽²¹⁾ says: "Little attention has been paid so far to the questions of who will provide continuing education and who will be prepared to undergo continuing education. What seems eminently probable is that the institutions which train workers are scarcely likely to be able to shoulder the added burdens of continuing education, or the periodic retesting of those who now provide health services. The main weight of the task will fall on the work institutions themselves and the community health centres will be no exception to the rule. To a degree, therefore continuing education will necessarily be built into the Centre just as on-the-job training will be an inescapable responsibility of those who administer such centres." Hall goes on to warn that community health centres will have to expect resistance to continuing education from many of their employees.

Such community college programs as exist (e.g. for medical secretaries) have usually been designed for solo practice or small partnerships and are unsuitable for groups. Arrangements to share programs with hospitals have resulted in irrelevant material being taught.

It cannot be assured that either community health centres or physicians in general practice will be able to develop continuing educational programs without having help from consultants and incentives built into the clinic for organizing these schemes. The business managers made it quite clear that they saw educational costs as a drag on their efficient administration.

LINKAGE PROCESSES: PREDICTIONS

It seems likely that each province will develop differing kinds of organization structures at provincial, regional and local levels, but all will have to cope with similar processes of negotiation and consultation about the development of a system. Intensive negotiation on budgets for each district and each

centre will be necessary. At the beginning of the new co-ordinated program, many allowances will have to be made for unseen contingencies, budgets will have to be prepared with care but should not be too inflexible.

The sociologists, Bell, Fish and New(22) who met with the Project research co-ordinator to discuss feasibility, support Elliott's(23) suggestion of limited control by consumers over financing at the beginning: "Innovative services especially in the early stages may be controversial. New role relationships are emerging and new patterns of behaviour are being learned. In this context external sources of strain should be minimized. A financial burden in conjunction with the organizational strains would most probably result in a community health centre never having a fair chance of survival."

The development of predictive models should be the first priority so that costs can be properly assessed, manpower costs particularly. "Pre and post" community health centre studies should be initiated. Then expectations can be checked from established baselines. This should enable the funding bodies to appreciate shifts from normal values, to heed warning signals about normal functioning and excessive conflicts, to take warnings of emigration and so on.

SUMMARY

There are two objectives in changing the present system of organization of health care:

- (a) to reduce wastefulness of resources
- (b) to change methods of providing health care

The sponsor of an ambulatory care unit might be one or more physicians, a consumer organization, a union, a business organization, a community group, a hospital, a medical school, a local medical society or the government.

Sponsorship has a predetermining effect on many of the structural elements which are decided when the organization is formed. Thus the identity of the sponsor (and the Board) is of critical importance. However, programs are not unilaterally

controlled but have to be negotiated with the local community of professionals and consumers.

Sponsorship has little effect on day to day economic performance since it does not directly affect delivery of services but it may have some direct administrative or publicity costs.

Is the function of the sponsors of a community health centre to shift some of the power away from the doctors towards the community?

In order to improve use of resources, positive incentives will need to be developed for sponsors and physicians.

Particular attention needs to be paid to incentives which will encourage physicians to keep their patients out of hospital. Kaiser Permanente provides the model of such a scheme but some questions have been raised about the needs of chronic care and welfare patients under this scheme.

Possibly incentives other than financial incentives should be considered to make physicians more aware of community care services (e.g. quality of care reviews).

Incentive reimbursement systems have been suggested as a possibility. These are being explored by hospitals but may be difficult to apply to group practices for reasons of case mix, etc. No research seems to be in progress on incentive reimbursements in group practices despite general interest in the idea. Global budgeting is being tried out in three Saskatchewan community clinics but it cannot be developed fully under present cost-sharing legislation.

Incentives could possibly be worked out to encourage isolated health workers to link themselves into a community network of care.

Perhaps physicians willing to locate in underdoctored areas should be encouraged through capital funding and operational incentives. Possibly consideration should also be given to incentives for working in experimental centres.

Disincentives might be developed by tightening administrative controls over surgical privileges and use of specialists as primary care physicians.

Patients might be given incentives to enrol with one physician or one group only.

If it is intended to develop one type of sponsorship rather than another, different incentives should be considered. Both hospitals and multi-specialty groups have claimed that they could provide community health centre services. Differences are discussed later. Here, questions are raised about profit making and profit sharing.

Incentives to individuals will be discussed in a subsequent chapter.

Professional communication and education for physicians has been centred in the hospital. This may not be appropriate if a community orientation is to be encouraged in general practitioners. Satellite continuing education centres should probably be developed outside university centres. These should take into consideration developments in interprofessional education in health science centres though these developments have still to be worked out properly.

There will be problems in organizing continuing education for employees of community health centres. Community College programs have not been helpful to group practices since they are geared to training secretaries/receptionists for solo practitioners. The cost of continuing education worries clinic business managers.

It is to be expected that there will be problems in budgeting for community health centres. Consumers should not have to take too much responsibility for financial matters in the early stages of community health centre development. Predictive models should be set up so that variations in expectations can be checked from established baselines. These predictive models should enable funding bodies to heed warning signals about conflicts within a centre which shows abnormal signs.

REFERENCES

1. Blackman, Allen: Sponsorship. University of Michigan, mimeographed, Ann Arbor. 1971.
2. Griffith, F.E.: Problems of an Administrator.
3. Evans, R.G.: Community Health Centres and the Cost of Acute Hospitalization in Canada.
4. Chase, M.I.: Some Administrative Problems and Experiences of a Business Manager in a Regional Multi-specialty Clinic. Part I - External Affairs, Part II - Internal Affairs.
5. Pearson, R.J.C.: Health Maintenance Organizations.
6. Logan, R.F.L.: Personal Communication.
7. Rein, Martin: Social Class and the Health Service. New Society, pp. 807-810, November 20, 1969.
8. Hardwick, C. Patrick, and Wolfe, Harvey: A Multifaceted Approach to Incentive Reimbursement. Medical Care, Vol. VIII, No. 3, May-June, 1970, pp. 173-188.
9. Rafferty, John: A Comment on Incentive Reimbursement. Medical Care, Vol. IX, 1971, p. 518 ff.
10. Anderson, D.O.: Personal Communication.
11. Anderson, D.O., and Crichton, A.: Economies of Group Practice in Saskatchewan, unpublished manuscript, University of British Columbia, 1972.
Anderson, D.O.: What Price Group Practice?
Crichton, A.: The Organization of Group Practice.
12. Detwiller, Lloyd: The Canadian Health Scene: Political Reality.
13. Rosenfeld, G.B.: Summary: Hospital Administrators' Seminar.
14. Babson, J.H. et al.: The Community Health Centre.
15. Smith, Neville: Ambulatory Health Care - The Views of a Clinic Physician and Review.

16. Crichton, Anne: Summary: Seminar on Business Management.
17. Hlynka, J.H.: Summary: Seminar on Pharmacists.
18. Govt. of Ontario: Satellite Continuing Education Centres in Ontario (for Medical Education) McMaster University, 1972.
19. Mechanic, David: Correlates of Frustration among British General Practitioners. J. Health and Social Behavior, 11: 87-104, June, 1970.
20. Larsen, Donald E.: Education of Personnel for Primary Health Care.
21. Hall, Oswald: Allied Health Professionals in Community Health Centres.
22. Bell, N., Fish, D. and New, P.: Report of Meeting in April, 1972.
23. Elliott, Jean Leonard: Citizen Participation in the Community Health Centre: Consumer Constraints upon the Emergence of New Forms of Ambulatory Care.

CONSUMER INVOLVEMENT

PUBLIC, COMMUNITY OR CONSUMER INVOLVEMENT

The differences between taxpayers' and consumers' involvement was discussed in Chapter 3.

Hospitals are health care institutions which have been made to respond to the public through legislative controls. They are required to develop by-laws to control efficiency and effectiveness. The tight controls, imposed by the Federal Hospital and Diagnostic Insurance Services Act, 1957, were represented, however, and when the Medical Care Act was passed in 1966 it was agreed that a more flexible scheme should be introduced. Consequently doctors' offices are not controlled through a system of by-laws in the same way as hospitals are.

Physicians are controlled by two mechanisms -- individual patients' demands, and peer group restrictions. These two mechanisms are now being challenged as inadequate. Whilst it is clear that physicians do respond to individual patients' demands, they have to do so in order to keep in business and Gouldner⁽¹⁾ has developed arguments about reciprocal roles which are helpful for understanding these one-to-one relationships -- they are not responsive to consumer group demands for system change. And if doctors can seek the support of their peers why cannot patients seek the support of theirs?

Dissatisfied consumers do not have any satisfactory mechanism for expressing their group demands for system change. Youth groups have been most visibly dissatisfied but their attitudes to the health care delivery system are seen to be part of a larger revolt against traditions in society. The same confusion about group goals may be seen in Indians protests.

So far as peer group controls over physicians are concerned these are technical controls only. They do not deal with inefficiencies and proper delegation to less skilled staff but only with adequate standards of conduct and practice.

Peer group controls over physicians by the professional colleges have already been discussed. For many people, these quality controls are insufficient. They do not deal with

inefficiencies and proper delegation to less skilled staff, but only with adequate standards of conduct and practice.

COMPLAINTS MACHINERY

A somewhat negative form of consumer involvement is to complain about neglect.

It has been suggested that complaints machinery might be strengthened so that an ombudsman's office might deal with complaints about publicly financed health care and that the Colleges should appoint representatives of the public to their complaints committees.

In some Canadian provinces there is an ombudsman's office for the sifting of complaints against government departments. Does the ombudsman have enough understanding of health care problems to be an effective investigator? Possibly this office could be strengthened to deal with grievances about health care.

Klein⁽²⁾ has discussed the problems of getting formal complaints dealt with in Britain. Mechanisms exist for consumers to make the National Health Service aware of and responsive to their wants and attitudes (i.e. verbal or written complaints to Hospital Management Committees and Executive Councils, letters to M.P.s) and responsive to allegations of "bias, neglect, inattention, delay, incompetence, ineptitude, perversity, turpitude, arbitrariness but these are not much used* The most recent and comprehensive survey...suggests that there is considerable ignorance about the mechanics of transmitting views, that patients prefer to talk out their grievances rather than writing them down formally and that, of those complaining, a high proportion are unhappy about the outcome..." "The most vulnerable patients - the old, the mentally ill and the handicapped - are often those least able to press their views." Klein asks: "How can the consumer be given a stronger voice? ... What incentives will the management side have (to have) to be responsive to consumer wants and wishes? What machinery will there be for dealing with maladministration?"

* The Parliamentary Commissioner is the British version of the ombudsman. - This list describes his remit.

Part of the difficulty is that professionals have continued to tell consumers that they are in no position to judge the technical quality of care. It is only now that consumers are beginning to ask whether this is the only thing that matters. Possibly what is important is a whole range of factors:

1. Acceptability (appointment keeping, patient satisfaction);
2. Accessibility (penetrance into eligible population, utilization);
3. Availability (hours of coverage, waiting times, walk-in service, after-hours coverage);
4. Comprehensiveness (range of services: clinical, home care, mental health, social health, health education, supporting services);
5. Cost (average unit costs of medical, dental, outreach services);
6. Efficiency (physician productivity, administrative turnover);
7. Manpower development (employment, training, mobility);
8. Quality of care (technical audit, continuity, physician turnover);
9. Responsiveness (information sharing, feedback mechanism).

As Klein points out, consumers have not known how to make an assessment of these factors, but evaluators in the U.S. and the U.K. are establishing scoring systems which the public could use in the future.

Another mechanism of control which will be discussed later (Chap. 18) is evaluation by an independent research or monitoring group with reporting back to the public.

CONSUMER INVOLVEMENT AS A DYNAMIC PROCESS

It would appear that community involvement as it presently exists is insufficient for a number of people; they want more positive personal consumer involvement in their own local health centres.

How much effort should regional boards make to get people to enrol members of community health centre associations? It is

only deprived populations or specially defined groups (e.g. the youth counter culture) who want an intensive kind of interaction in health centres. It was agreed in the physicians' seminar⁽³⁾ that some patients might not wish to become so intensively involved in their health centres as others but involvement or detachment was not a matter of social class. Middle-class people might have as much or more interest than the poor and might like more opportunities for involvement than they have now.

The concept of improving opportunities for all citizens is an active as well as a passive idea. Consumer participation is regarded as an important activity. It has become a matter of political principle in Quebec which has legislated for the inclusion of the users of health centres on their management boards. During the last 10 years there has been much discussion of strategies of social action to combat urban and rural alienation from the rest of society.

In the Sherbrooke area of Quebec, social workers in the office of the Fédérations et Conseils du Canada are engaged in community development in the towns in which community health centres are to be opened. Subsequently, it is intended that each Centre local de Service Communautaire (C.L.S.C.) will have an information officer, but clients with difficult problems will be referred to specialist social workers in welfare agencies. However, the social worker in the centre will be available for crisis intervention.

The C.L.S.C. in Montreal are more action oriented for the community and concerned with pressing for changes in socio-economic conditions in the depressed districts where they are situated.

In the U.S.A., federally funded neighbourhood health centres have been expected to develop community 'participation' in the operation and administration of their programs. The form and content of that participation were intentionally undefined. The programs have also been required to maintain certain data on program performance. A variety of patterns of participation have developed over the past five years. Some programs have developed under community control while most have developed under professional control.

Definitions of participation, control, involvement were discussed, in Chap. 3. However, it is important here to recapitulate. New⁽⁴⁾ points out that citizen participation,

control, involvement, decision-making and advice, are separate but linked ideas. "One may participate without having any decision-making powers or one may participate without any power to control. At the same time, each of these components may also be seen as stages in the total development of a community health centre. Participation may lead to control. Advisory functions of citizens may lead to decision-making powers... A major danger of citizen involvement occurs when the citizens' role is not clearly defined, but even (so) ...they may wish to shift from an advisory capacity, for instance, to a policy-making one. (It would be necessary) to accommodate and tolerate these changes."

Klein(5) points out that in European health services, "the trend is, if anything, away from involvement...In practice, there is very little evidence to suggest that homo sapiens is necessarily homo participans... The real explanation for the current enthusiasm for involvement by students, blacks and the poor is almost certainly not interest in involvement as an end in itself but as a means or an instrument for securing control of resources." He sees the revolt of the consumer as not only against the medical profession attempting to assert its autonomy, but also against the "technologization" of medicine.

CONSUMER INVOLVEMENT AS A PROCESS OF SOCIAL INTERACTION

Elliott(6) lists the reasons why sponsors might wish to start community health centres and why patients might welcome the change.

"Providers (or planners) might be influenced by the following reasons:

- (a) The health system as presently structured is not meeting the health needs of the people.
- (b) Primary care in out-patient departments and emergency rooms is often "too little and too late".
- (c) There is a shortage of primary care physicians and those available are not distributed with respect to the health needs of the population.
- (d) A C.H.C. could be part of a training program, exposing students to patients in a community setting.

- (e) In exploited or polluted communities the C.H.C. might be a focus of attack on the basic pathology.
- (f) Humanitarian concerns in medicine might lead in the direction of a C.H.C. as the C.H.C. is usually formulated as a way of bringing medicine into low income areas.

"Another set of arguments, although not necessarily contradictory to those of the providers, might be put forth by the consumer, (patients or social-work clients). They are as follows

- (a) Increased accessibility to primary medical care.
- (b) The C.H.C. would provide an opportunity for citizen input concerning program priorities and resource allocation.
- (c) Decentralized facilities may mean greater satisfaction in the utilization of health care facilities than that now experienced in dealings with the health bureaucracy.
- (d) So-called "new careers" may appear for community residents such as health workers in the clinic and out-reach workers in the community, providing health education, transportation, etc.
- (e) The C.H.C. could provide the community with a base for social animation or development; health would be viewed in its broader context -- housing, employment, legal aid, welfare rights, family planning, child care, marriage counselling, etc.
- (f) The C.H.C. might be conceptualized as one aspect of a wider social movement encapsulated in such slogans as "participatory democracy", "self-determination", and "grass-roots accountability."

"In any given health centre, it might be assumed that the consumers and the providers would embrace some of the above-mentioned incentives to varying degrees, and the incentives or principles adhered to by each party would colour their behaviour in the C.H.C. If we were to view citizen participation in terms of a continuum and innovative attitudes on the part of the providers of health services as a continuum, the following statement concerning the effectiveness of the C.H.C. might result by inter-relating the two variables.

Chart 14

COMMUNITY HEALTH CENTRE EFFECTIVENESS

CITIZEN PARTICIPATION IN THE CHC

	High	Low
Receptivity to Innovation on the part of the providers	High High effectiveness	Medium effectiveness
	Medium Medium effectiveness	Low effectiveness
	Low Low effectiveness	Medium effectiveness

"In Chart 14, C.H.C. "effectiveness" is conceptualized as an absence of conflict and agreement on the part of consumers and providers concerning the basic structure and function of the C.H.C. That is high effectiveness in the C.H.C. would result when high consumer participation occurs with high receptivity to change on the part of the providers of services. (It is also assumed in the table that the consumers are a monolithic group with shared definitions of the situation while in reality both consumers and providers might be expected to evidence some within-group differences in regard to certain issues confronting the C.H.C.)"

CONDITIONS FOR EFFECTIVE CONSUMER PARTICIPATION

Elliott has also set down what she believes to be conditions eliciting effective consumer participation in a community health centre.

"The model of any particular community health centre should fit the characteristics and needs of the community in which it is situated. This implies giving consideration to:

1. providing services which are user-oriented.
2. willingness to participate. This may vary considerably in relation to

- (a) the amount of medical deprivation which consumers may consider they had prior to the establishment of the centre. (Haughton⁽⁷⁾ also discusses the build up of resentments about deprivation)
- (b) the focus upon health as an issue in competition with other problems (e.g. unemployment, housing, etc.)
- (c) the general level of community interest in 'rights' to services
- (d) positive past experience of working in formal organizations
- (e) community demographic characteristics conducive to consumer participation - age/sex, social class, ethnic variable,

3. indirect financing."

PROBLEMS INHERENT IN CONSUMER PARTICIPATION

Though consumers may be anxious to make changes they may not know how best to set about it. As Warner⁽⁸⁾ points out, professionals are highly organized, consumers are "almost chaotic in their organization by comparison."

Objectives in terms of consumer involvement are not clear. Elliott says: "one should be aware of the contemporary socio-cultural and historical forces influencing the emergence of new forms of ambulatory care. These larger societal forces may be responsible to some extent for the success or failure of the community health centre concept. The three principal actors in the community health centre - health professionals, government and citizens - have scenarios scripted for them in part by the shared values, attitudes and beliefs characteristic of their relative positions in the Canadian social structure...In much of the interaction between consumers and providers, the consumers occupy the lower status position. Consequently, if the consumers' needs and priorities are at variance with those of the dominant group, the professionals and government, accommodative behaviour on the part of the latter might at times be appropriate." She continues "There is no reason to assume that the potential consuming public of a community health centre is monolithic with respect to their attitudes, beliefs and values. That is, although consumers may be represented in some fashion on the board of a

community health centre, it does not necessarily follow from this representation that the consumers on the board are representative of the consuming public of the community health centre. Consumers on the board of a community health centre are by definition of higher status than those who do not hold such a position, at least within the context of the community health centre population. Higher status actors may tend to manipulate those lower in the status hierarchy. Since there is no reason to assume that health consumers are an exception, one might expect higher status consumers to dominate lower status ones unless structural safeguards are built into the governing body of the community health centre. Although a consumers' group may be highly responsive to the needs of other consumers, this may not always be the case. In fact, the reverse is possible. The behaviour of consumers in a community health centre may at times be counter-productive to the establishment of services in the best interest of the population as a whole."

Elliott goes on to discuss problems inherent in consumer participation:

1. "vested interests;
2. representation: who is representing whom?
3. personal status issues leading to manipulation of others;
4. personnel problems with indigenous workers - change of loyalties or perceived change;
5. ephemeral nature of consumer participation;
6. division of insiders and outsiders;
7. different financial priorities of consumers and providers".

INSTITUTIONALIZATION OF CONSUMER INVOLVEMENT

How much power, at what levels, should be reallocated to Canadian consumers of health services? How fast should changes be initiated and carried through?

Elliott points out that consumer involvement will depend upon government sanction. Because governments control the purse-strings and can legislate, they have the ultimate authority.

Klein⁽⁵⁾ discusses the development and institutionalization of consumers' power: "Any form of involvement can be either the result of a concession by the dominant profession or a consumer right: that is, it can be either an ad hoc arrangement or

an institutionalized agreement (though there may often not be an absolutely clear dividing line: note the importance of custom in factory floor relations). In turn, the degree to which involvement is concessionary or as of right will be determined by the distribution of power within any system.

"If professional dominance is high in a service like health, then it is likely that any consumer involvement will be limited to information or consultation at the most, and on a concessionary basis at the discretion of the doctors. If the consumer influence becomes stronger, then information and consultation may become rights, with concessionary opportunities for consultation and perhaps even negotiation. Lastly, as consumer dominance becomes more pronounced, one would expect a move towards participation - ending up with a blocking veto as the last stage before complete consumer control". (See Chart 3, Chap.3).

THE COST OF CONSUMER INVOLVEMENT

Klein (5) says that the question is not "should consumer involvement be taken for granted? but "why should consumers bother to get involved?" He points out that involvement is a costly process: there are information costs, organization costs, representation costs and execution costs (i.e. carrying through decision). These tend to be recurrent and growing costs.

He suggests that those involved are likely to feel personal benefits but the more general costs should be assessed. These are related to:

- (i) the specific resources at stake (the greater the resources, the more involvement is justified),
- (ii) the ability to exert influence over outcomes,
- (iii) the size of the group involved in the discussions,
- (iv) the certainty of the benefit,
- (v) the salience, or life and death quality, of the benefit,
- (vi) the permanence of the benefit.

"Consumer involvement is intense when consumer profits are high. Consumers invest in involvement when they can gain relative advantages at the expense of others...Some practical conclusions can be drawn for policy-making. If the aim is to encourage consumer involvement, then it is essential to make information as cheap as possible and to avoid such information becoming the monopoly of

any professional body...Public policy must choose between encouraging a high degree of consumer involvement and establishing rigid national norms of resource provision (for) emphasis on the latter (unless they are minimum standards) is bound to weaken the incentives to involvement.

For middle-class people, traditional forms of social service remain open as before. These may be more satisfying to them than the new proposals about local community health centre involvement. On the other hand, there may be great interest in consumer involvement at regional or provincial levels where the sorting out of priorities in allocation of resources or the negotiation of contracts would be an important activity.

Klein's analysis suggests that it may only be minority groups in deprived sectors of society who feel it worthwhile to take up this new form of consumer involvement at local health centre level. If so, Haughton suggests, these are the questions which must be answered:

- "(a) How can an institution or agency identify its community?
- (b) Having identified the community, how does the agency determine who really speaks for that community?
- (c) What advantages can an institution expect from having community representatives on its board? (Community representatives being users of the services).
- (d) Low income representatives incur costs in attending meetings and serving on governing bodies- how are these costs to be met?
- (e) How can community representatives be educated to the intricacies of health economics, politics and managerial problems?"

As New and others have pointed out, the demand for participation in management of a community health centre is likely to stem from dissatisfaction with institutional and professional processes. There is a demand from minority groups of various kinds, for more concern about their perceptions of social processes in the treatment they are getting.

The only way in which dissidents think they can force professionals and their assistants to care is through the sharing of sponsorship power.

CONSUMERS' INTEREST IN RESULTS

The questions which are being raised by thoughtful consumers are not about long term health outcomes so much as about the sharing of power to determine what the programs and processes should be. Outcomes are remote; they seem to be too distant, too technical, frequently beyond personal control, unrelated to individual behaviour. On the other hand, processes and structures are immediately relevant.

"It is the second dimension of the community's voice, the one which demands certain specific screening, diagnostic and treatment services that lacks scientific validity. Planning treatment services on the basis of the second dimension carries with it no guarantee that the resulting diagnostic and treatment services will have either a favourable impact upon health or an acceptable price tag."

"Health professionals' undocumented judgment is unsound," says Sackett⁽¹⁰⁾ and 'the community voice' may not always be sound in its judgments...This community voice has two dimensions and it is important to distinguish between them. The first of these expresses the community's concerns about the accessibility of health care, its cost and convenience, and the social value of different states of health. This is an important dimension for planning and evaluating, and its recognition strongly supports consumer-sponsorship of innovative community health care programs.

Griffith's⁽⁹⁾ experiences as manager of a group health centre suggest that even when there is a community board the professionals will do their work in traditional ways. Sponsorship by community boards is not enough to change existing patterns of work organization in clinics unless the patterns of funding are also changed because the present fee-for-service system leaves the physicians in control of administrative as well as clinical decisions.

These comments suggest that the funding system needs to be changed, new methods of budgeting and new incentives introduced,

and assistance given to consumers on how to evaluate their centres. With these changes, consumer involvement in management could possibly lead to greater scrutiny of expenditure and perhaps better services for the same outlay.

CONSUMERS AS WORKERS IN THE COMMUNITY HEALTH CENTRE

Because consumers might become involved in working for the centre, either as paid staff or volunteers, better services might be made available to the local community, but this form of consumer involvement will be discussed in Chapter 17.

The evidence suggests that community involvement will be gradual and probably quite slow unless special circumstances hasten its development.

SUMMARY

Some controls over investment and practice standards in health care already exist. These are well developed for hospitals and other corporate bodies, less so for physicians.

To some extent physicians are controlled by their role relationship to patients, but these power relationships are very unequal particularly when doctors have peer-group support and patients do not. Patients are now asking for this peer-group support too.

Peer-group controls of professionals deal with adequate standards of conduct and practice but not with inefficient use of time and poor delegation of work.

Complaints machinery might be strengthened by use of ombudsmen or the extension of membership of Colleges' complaints committee to laymen. (Complaints are probably as much about "technologization" as medical dominance). Individuals are not well aware of complaints mechanisms. Consumers are probably less concerned about quality of care than about standards of acceptability, accessibility, availability, comprehensiveness, cost, efficiency, manpower development, continuity, responsiveness. Consumers may need to be trained in how to evaluate delivery systems.

Consumer involvement in Quebec is an active as well as a passive idea. In some areas people have become disillusioned about democratic processes and the ability of governments to solve the problems of minority groups.

C.L.S.C. in Sherbrooke have community development officers, information and crisis services. Action orientation differs there from poorer districts of Montreal. In the United States, Neighbourhood Health Centres have been set up for purposes of developing participation. People may not wish to become participants in the C.H.C. consumer activities unless they wish to shift power. In Europe the trend is, if anything, away from community involvement.

Planners' reasons for wanting to start community health centres are listed:

- (a) the present system is not meeting health needs,
- (b) emergency room care is too little and too late,
- (c) physicians are badly distributed and there is a shortage in some areas,
- (d) community health centres might train students in community care,
- (e) community health centres might be centre of attack on a pathological community,
- (f) community health centres might bring medicine into low income areas.

Consumers' reasons for wanting change are:

- (a) citizen input opportunities,
- (b) decentralization, less bureaucracy,
- (c) new careers for local people,
- (d) base for social animation,
- (e) development of participatory democracy.

But planners' and consumers' views will not coincide on all issues relating to community health centres and in consequence an effective community health centre may not be established. Elliott thinks that the model of the community health centre should fit the characteristics and needs of the local community by (1) providing services which are user-oriented; (2) considering willingness of consumers to participate (which will be related to community composition and past experience); (3) indirect financing. For consumer boards to cope with financing at the beginning would be too great a strain.

There are many other problems inherent in consumer participation.

1. vested interests,
2. representation,
3. personal status issues leading to manipulation of others,
4. personnel problems with indigenous workers re changes of loyalties,
5. ephemeral nature of consumer participation,
6. division of insiders and outsiders,
7. different financial priorities of consumers and providers.

Consumer involvement will depend upon government sanction because governments control the purse-strings and can legislate. It will also depend upon negotiated agreement with professionals.

Why should consumers bother to get involved? Consumer involvement is costly and costs are recurrent and growing. It is important to assess whether costs are worthwhile to the community. Consumer involvement would be intense when consumer profits are high. "Public policy must choose between encouraging a high degree of consumer involvement and establishing rigid national norms of resource provision because emphasis on the latter is bound to weaken the incentives to involvement."

Possibly only minority groups in deprived sectors of society will be interested in involvement. If so, there are major problems of: defining community boundaries, defining representatives,

deciding on what are the advantages of having representatives, paying costs of representatives, educating representatives in committee behaviour.

There remain traditional forms of involvement in voluntary organizations for middle-class people. Development of new forms is likely to be slow.

The community may not always make sound judgments. It will make a useful contribution on accessibility of services, costs, convenience and social value of different states of health, but it will not be sound on technical matters such as screening. Assistance needs to be given to consumers to help them to evaluate their centres.

Consumers are less interested in long-term outcomes than in processes, change in sponsorship is unlikely to change process unless methods of funding also change so that teamwork can be organized on a basis of equality.

Consumers may become workers in their centres.

REFERENCES

1. Gouldner, Alvin W.: The Norm of Reciprocity: A Preliminary Statement. Am Sociological Rev., 25: April 1960, p.161.
2. Klein, Rudolf: Accountability in the National Health Service. Reprint, London School of Hygiene, 1971.
3. Greenhill, Stanley: Summary: Physicians' Seminar.
4. New, Peter K.: Community Health Centres: Five Danger Signals.
5. Klein, Rudolf: Notes Towards a Theory of Patient Involvement.
6. Elliott, Jean Leonard: Citizen Participation in the Community Health Centre: Consumer Constraints upon the Emergence of New Forms of Ambulatory Care.
7. Haughton, James: Citizen Involvement in Health Affairs.
8. Warner, M.: Consumer Education and Re-Education and New Forms of Health Care Delivery.
9. Griffith, F. E.: Problems of an Administrator.
10. Sackett, D.: Evaluation of Innovative Community Ambulatory Care Programs during Periods of Social Change.

PROFESSIONALS' ATTITUDES TO CHANGE AND SOME ADMINISTRATIVE BARRIERS BETWEEN PROFESSIONS

PROFESSIONAL REACTIONS TO THE CONCEPT OF THE COMMUNITY HEALTH CENTRES

Fish⁽¹⁾ examined briefs to the Project, the case studies and relevant seminar papers and reports and summarized reactions of professionals to the concept of community health centres. He says that "without community involvement the objectives set for community health centres could not be achieved, consequently the principal concern of the professionals is the degree of community involvement."

THE PHYSICIANS' ATTITUDES

"The concept of a community health centre includes the provision of health services and there is an implicit assumption that doctors will provide the backbone of the health services delivered in a community health centre.

"Any discussion of the role of the doctor in the community health centre is fettered by the assumption that the doctor will play some kind of leadership role within a community health centre; that is, he will not be responsible merely for the provision of technical medical services but will play a part, to a lesser extent, in determining the policies of and administering the community health centre. In part, this reflects a tacit acceptance of the community-at-large of the special power and authority of the doctor in the area of the delivery of health services; it also reflects acceptance by the medical profession of the belief that doctors are, in fact, the only ones capable of making effective decisions with respect to the organization and administration of medical services."

Fish thought that the documents he examined showed that the medical profession was resistant to the concept of community health centres principally because practicing physicians fear lay control and changes in payment systems. The reaction of the medical profession has been exacerbated to some extent by the insistence of advocates of the community health centre concept on

placing the blame for failures in the delivery of health services and for rapidly rising costs at the doorstep of the medical profession. The insistence that cost can only be controlled and effective health services delivered if the style of practice and methods of payment for the medical profession are substantially modified is not guaranteed to encourage the medical profession's support for the community health centre concept.

1. "Lay Control: The feature of the community health clinic which is likely to find most disfavour with the medical profession is that of community involvement unless the degree of this involvement is clearly specified. The idea that the lay community might be in a position to dictate policies with respect to delivery of medical services is anathema to the medical profession.

Up to the present, there has been little attempt to clarify the nature of the control of medical practice which will be exercised by a lay board. Advocates of the Community Health Centre concept may argue that policy decisions of the boards with respect to allocation of block budgets and resources would not affect the sacrosanct relationship between the doctor and his patient. The doctors, on the other hand, perceive a lay board as the potential source of control of their medical decisions.

2. Mode of Payment for Doctors: As might be expected, there is resistance, both implicit and explicit, towards changes in the mode of payment for doctors working in community health clinics. The resistance of organized medicine to the introduction of a mode of payment other than the traditional "fee-for-service" arrangement is too well known to be documented here. Nonetheless, it would be cynical, if not erroneous, to conclude that the only, or even chief, basis for resistance to the community health clinic by organized medicine is in economic terms. Rather, the data suggest that the economic arrangements advocated by the medical profession are symptomatic of other more fundamental problems. Certainly, the evolution of organized medicine's viewpoint on economic arrangements lead one to be more than optimistic about the acceptance of the medical profession of an erosion of the sacrosanct idea of "fee-for-service".
3. Freedom of Choice for the Patient: One important tenet of organized medicine is that the patient should have the

freedom to choose his own physician. Presumably, the doctor has the freedom to accept, or not accept, a patient. The profession has expressed concern that the introduction of community clinics will "lock in" the patient to a specific institution and that the patient, thereby, may abrogate his right to select his own doctor.

4. The Concept Already Exists: A fourth line of resistance occurs along the line that many private practitioners, particularly those working in groups, are already practicing within the general guidelines of the community health clinic concept. It is argued that the use of various social agencies, if not the employment of social workers in the practice itself, constitutes the broad spectrum of services proposed for community health clinics, while the lay boards of local hospitals ensure citizen participation in the running of the health services.

Notwithstanding these evidences of resistance to the concept, organized medicine has placed itself on record as being in favour of the concept, at least to the point of encouraging experimentation in it. It is difficult to say at this point whether this attitude represents a tacit acceptance of a future form of health care delivery or whether it is an acceptance of a currently popular proposal which is thought to be likely to flounder in its experimental stages. In either case, direct confrontation with governments is avoided and the willingness of the medical profession to co-operate cannot be questioned.

A review of the case studies of emergent community health centres has not been helpful in indicating the role of physicians properly organized in a system of community health centres.

Several points, however, do stand out:

1. Doctors who play an initiating role in establishing a community health clinic or who commit themselves on a full-time basis to a community health clinic tend to be somewhat missionary in their orientation. The term missionary is not intended to convey any particular religious connotation but rather a commitment to a cause. The term missionary is not used in a derogatory sense: it does, however, convey the implication that doctors who have accepted full-time

commitments with community health centres are probably inherently different from those who have adopted more conventional modes of practice. The numbers are too small and the data too thin to report on other than an intuitive basis.

2. Where community clinics have been initiated by university students doctors have been willing to offer their services on a part-time and limited basis. These doctors have usually been doctors from the faculty of medicine and their commitment may have been more to the students than to the clinic which the students were operating.
3. Several clinics have been either community or agency sponsored employing doctors on a full-time basis. The cases are too few to draw any generalizations with respect to the feasibility of recruiting doctors on such a basis but it does appear that (a) such clinics find it difficult to recruit and (b) the rate of turnover is high, and (c) the doctors recruited tend to be marginal individuals for one reason or another."

DENTISTS IN THE COMMUNITY HEALTH CENTRES

"MacFarlane and Reid⁽²⁾ are categorical in their prediction of constraints in the development of dental health services in the community health centre context. They rest their argument on three points:

1. The dental profession is unlikely to be willing to practice in any great numbers in a setting such as a community health centre where the presence of auxiliaries is a central feature of the rationalization process. MacFarlane and Reid do not feel that the dental profession has reached the point where considerable delegation of responsibilities is likely to occur.
2. New modes of payment for services are likely to discourage dentists from locating in community health centres. In this respect, the adherence of the dental profession to the traditional fee-for-service arrangement is stronger than that of the medical profession and few examples of salaried dentistry exist in other than university or government institutions.
3. Dentists are likely to be reluctant to accept the leadership of supervision of doctors within the community health clinic

setting." MacFarlane and Reid say that "if dentistry is to be an integral part of the community health clinic setting, dentists have to be brought in as a full-fledged partner in the health domain and not as second-class citizens in the land of medicine."

It would be good to be optimistic about the future, but MacFarlane and Reid, basing their remarks on recent extensive studies of dental students and faculty in Canada, argue that there is little evidence in the dental educational system of change in the professional attitudes of students or in the professionalization process within the dental school. They argue that dental schools still tend to recruit dental students who are oriented to autonomy and independence in professional life, both of which characteristics which may be at odds with the community health centre concept. Further, they note that dental students appear to value highly the opportunity to employ sophisticated manual skills, a traditional aspect of the practice of dentistry. Given this characteristic, the delegation of even routine manual tasks to auxiliary workers is likely to be a slow process.

Evidence from dental practices which have been set up in community health clinics to date appears to suggest that MacFarlane and Reid are right in their analysis. In one centre it is noted that there are seven dental chairs but Dental hygienists do not seem to be part of the dental services...which is all the more remarkable because of the interprofessional flavour of the whole project. In other community health clinics the dental services appear to be very much a service function largely concerned with restorative dentistry.

It appears logical to make dental services available within the same institution and particularly to mount a program of preventive dentistry which, in the long term, might substantially reduce the need for restorative dentistry. The feasibility of doing so, however, is likely to be inhibited by difficulties in the recruitment of dentists and dental auxiliary workers to work in a community health centre.

ATTITUDES OF NURSES

The strong desire of nurses is to be admitted into aspects of community health care, other than the traditional public health or Victorian Order of Nurses' activities. The present restricted roles of nurses in doctors' offices has already been discussed. Much of the professional groups pressure towards change is coming from the nurses. Churchill⁽³⁾, Kergin⁽⁴⁾ and the nurses' seminar group⁽⁵⁾ were anxious that legal and funding mechanisms should be amended in order to enable nurses to do more. They all thought that community health centres could offer a new opportunity to nurses who are presently very much circumscribed, for if these new organizations are to take on the responsibility of continuing care-surveillance, maintenance and restoration then it seems unlikely that they will be able to do so without delegation of more functions to nurses. However, Steele⁽⁶⁾ has pointed out that patients as well as physicians will have to change their attitudes if more use is to be made of nurses. Presently, patients insist on seeing doctors about their medical problems, however simple, and often their social problems too.

Greenhill⁽⁷⁾ analyzed the supply of nursing personnel in Canada. In 1968, there were 143,783 nurses, of whom 4.3% had university degrees, 65.7% had diplomas and 30.1% were nursing assistants. The nurse population ratio was 1.207, i.e. professional nurses with active practice licence and employed full-time. This favourable ratio of nurses to the rest of the population is increasing and Canadian nurses are a more highly educated and skilled group than the nurses in other countries. As Logan⁽⁸⁾ points out: "For an efficient nursing service with nurses working according to a hierarchy of skills one would expect more assistant nurses and other nursing auxiliaries led by a qualified nurse." It is important, then, for Canada that better use should be made of the many highly trained nurses. (see Chart 7 p.7-8)

AMBIGUITIES IN THE ROLE OF SOCIAL WORKERS

"Fundamental to the community health centre concept is the development of social services alongside the traditional health services" says Fish. "In part, this is a recognition of the

integral relationship between physical and social variables but it also stems from a belief that many of the tasks presently performed by health professionals might be more effectively performed by professionals from the social work field. These two objectives, first to integrate the social and health services and the second, to substitute social for health manpower, place somewhat different restraints upon the feasibility of the implementation of the community health clinic concept. In the first case, the feasibility will rest on more global considerations which will include the willingness of government and agencies to abrogate some authority to the community health clinic in the area of social development and welfare. To date, no community health clinic has attempted to draw within its ambit the full range of social services and one would question whether merely housing the various social service agencies within the community health centre would guarantee the kind of interchange between the health and the social services that is thought to be required for functional integration.

The feasibility of the substitution for health professionals of social workers also raises a number of questions. Clinic experience to date suggests that social workers are by no means agreed on the role which they should play in a community health centre and there is little evidence of a clear understanding by the medical profession, at least, of the functions of a social worker within the community health clinic setting. Some of the problems arise from lack of understanding of the various competencies of the social and health professionals. This is likely to occur not only between doctors and social workers (as pointed out by Ghan⁽⁹⁾) but also between the social worker, the public health nurse, and general office nurse. The confusion arises, in part, from the disparity of definitions held by social workers of their potential role in a community health clinic.

INVOLVEMENT OF ALLIED HEALTH PROFESSIONALS IN COMMUNITY CARE

Community health centres would wish to employ other health professionals: nutritionists, physiotherapists, occupational therapists, clinical psychologists, speech therapists, chiropodists, laboratory and radiological technicians, medical record librarians and technicians and possibly optometrists and chiropractors as well.

Because they are still struggling for recognition as professionals, these workers will need to be given adequate consideration and proper support if they are to make a useful contribution in community health care settings. One symbol of this will be the method and level of remuneration. The seminar group⁽¹⁰⁾ of allied health professionals made much of the need to relate scales of payment to qualifications, experience, seniority, hours of work, etc.

PROSPECTS FOR CHANGE: THE EFFECT OF REGISTRATION AND LICENSING SYSTEMS

Nurses are registered, not licensed to practice, as are physicians and dentists. Consequently, nurses who treat patients have had to do so under the direct supervision of a physician except in special circumstances when doctors are not prepared to take up practice and nurses with special training are allowed to do outpost nursing.

It was suggested by the legal group seminar⁽¹¹⁾ that community health centres should become corporate bodies like hospitals so that nurses and other allied health professionals could work under the aegis of organizations and be given legal coverage. Where appropriate they should work under the close supervision of a physician but in many cases this would not be necessary. Nurses could then pay home visits to old people, referring them to physicians if they needed medical attention, or they could screen cases in the clinic without having to bring the doctor into the room. This new legal status for the community health centres would enable the nurses to develop expanded roles and social workers to offer psychotherapeutic, information or family counselling services as fully qualified team members working to their full capacities.

PROSPECTS FOR CHANGE: THE EFFECT OF PAYMENT SYSTEMS ON PROFESSIONAL RELATIONSHIPS

The cost-sharing regulations have limited the employment opportunities of nurses and other allied health professionals because the Medicare system has continued to pay only physicians for their services with a few exceptions.* By paying fees for items of service, the onus has been put on the physicians to decide whether to employ assistants or not.

It is unlikely that teamwork which uses the skills of others working with physicians can be developed properly until global budgeting or some system of capitation payments for health centres exists, for until then there will be little or no incentive for physicians to delegate to others. Presently, most physicians seem to be anxious to preserve the fee-for-service system but many nurses and others are anxious to change it so that they can make a breakthrough, get more responsibility and reform teamwork.

What the nurses and the social workers would like to have is the same method of payment as physicians, whether salaries or fees. What they resent is the different method by which they are now remunerated. It seems to set them apart. This does not mean that they are claiming the same levels of pay, though the relative differences at the present time are another matter of grievance.

So, unless new forms of funding and new mechanisms of payment are devised, it seems unlikely that real teamwork will be able to emerge or that better ambulatory care can be delivered.

Griffith⁽¹²⁾ develops the theme that it is not easy to be the business manager of an organization which is staffed by professionals who are paid on fees-for-service.

"In addition to the external forces affecting personnel, the internal uncertainties regarding the point of ultimate control in the policy-making bodies has an adverse effect on supervisory and other staff. Conflicting instructions from doctors and administration, combined with staff attempting to play one

*Some provinces contract with physiotherapists, chiropractors etc. but these exceptions are few.

authority against another, combine to create difficult administration. There is always real difficulty in controlling personnel who may be responsible professionally to one authority and administratively to another. If the board or medical group interfere at the administrative level, effective management must be wastefully directed in order to deal with the results- which it must do or completely lose control."

There are some indications from the Sault Clinic that the different methods of remuneration lead to militancy. Nurses have made strong demands not only for more pay but for staffing patterns which suit them. It appears that without a change from the present fee-for-service system the hospital model of teamwork is likely to predominate and this would be unfortunate. (see Chapter 17)

POSSIBLE CHANGES IN PAYMENT SYSTEMS

The problem is not only how to change the present system, but also how soon it can be changed. The professions have different timetables. Physicians seem to be unwilling to permit rapid organizational change, whereas nurses are anxious to extend their role and make a better contribution. As Ruderman⁽¹³⁾ suggests, it may be important to remove some of the uncertainties from career planning of physicians by setting up a central information agency, for much of their resistance to change stems from their personal uncertainties about job prospects over the long term.

But the public may not be willing to wait very long for change. As one of the committee members of this Project has said:

"Medicare has put medicine into the public domain irrespective of individual doctors' and dentists' desire for private entrepreneurship. Arguments which applied in the private sector do not now apply. It is a new ball game." Others have pointed out that, if there is to be increased delegation of work to nurses and allied health professionals, the public will not be willing to accept that all of the services should be paid for at doctors' fee-schedule rates or paid directly to the physicians to be distributed at their discretion to assistants.

MODIFIED FEE-FOR-SERVICE PAYMENTS

Armstrong⁽¹⁴⁾ is afraid that there may be a flight of physicians to other countries if too rapid a change is made. He has drawn attention to the DIFAM⁽¹⁵⁾ method, a theoretical model of a modified fee remuneration system. He thinks it might be wiser to try out something of this kind rather than capitation or salaries. "It is a fee-for-service method, but does not involve the use of a fee schedule or schedule of benefits.

"Fees for each service are computed from the time taken to render the service, modified by various weights, or factors. Each participating doctor submits a daily claim sheet listing each item of service with its service-time and an individual service factor assessed by the doctor himself. He bases his service factors on difficulty and responsibility, checked against a list of standard service factors. These standard factors will have been developed by the insuring agency to achieve particular cost levels for individual types of service, types of physician and total liability for coverage. Multiplication of the time in minutes by the service factor gives a unit value for each service. Each doctor has an individual cost factor for office, home and hospital work which he has arranged with the insuring agency. The appropriate cost factor is applied to each of his unit values to produce corrected unit values, the sum of which is the day's total corrected unit value. This figure is modified by a workload factor relating to the number of services rendered during the day to give a final unit value. Fixed training and location factors, applicable to each doctor individually, are then applied to the final unit value, to give a final adjusted unit value, which is converted into a sum of money by applying a fixed dollar value per unit. All this computation is done by electronic equipment at the insurance office.

This system is not in actual use anywhere. It is presented here as a model which has been worked through to produce rates of payment to physicians which correspond as closely as possible to the rates paid for the same volume of services according to a fee schedule which is in use. The schedule chosen for this purpose was the 1967 Schedule of Fees of the Ontario Medical Association which forms the basis of payment by the Ontario Medical Services Insurance Plan of the Ontario government, as well as by Physicians' Services Incorporated and the other doctor-sponsored and commercial insurance carriers in Ontario. The model could be constructed equally well to bring about any other scale of payment rates, either existing or hypothetical. Adjustment of the factors is all that is required.

SESSIONAL PAYMENTS

Logan⁽¹⁶⁾ suggests that a system of sessional payments may be a useful method of remuneration to consider, as a half-way measure between capitation and fee-for-service. This is, of course, the method by which specialists with hospital appointments are remunerated in Britain.⁽¹⁷⁾

However, Logan believes that the introduction of such payment system for primary care physicians, would need to be coupled with "restriction and retreading of medical and nursing manpower" and "the need for one day samples of caseload to indicate what is going on now and to monitor any experiments for the future."

Anderson⁽¹⁸⁾ supports Logan: "Sessional payments are in fact probably at the heart of most agreements between physicians and groups."

CONTRACTS OF EMPLOYMENT INCLUDING GOOD FRINGE BENEFITS

It seems possible that some physicians may have been pushed into entrepreneurial activities rather against their will or their inclination. Possibly some would like the opportunity to become 'organization men' - to seek for contracts of employment similar to those of university teachers, with a series of fringe benefits: transferable pensions, paid holidays, paid educational leave, paid sickness absence, locums or coverage during time off, and overtime pay for exceptional work loads. This would ensure that administrative, teaching and research activities could also be carried out without undue strain.

REWARDS FOR PERFORMANCE

"Every payment system has advantages and drawbacks", says Glaser⁽¹⁹⁾. "Attention should be paid, however, to methods of rewarding superior performances, sorting out practice expenses from personal income, giving incentives only where it is possible to follow through (e.g. from diagnosis to treatment), removing

administrative barriers to patients seeking care (i.e. no deterrence fees), encouraging proper distribution of specialties especially those which tend to be undervalued by the profession itself and providing machinery for expert review."

SUMMARY

Without community involvement the objectives set for community health centres could not be achieved, consequently the principal concern of the professionals is the degree of community involvement.

The physicians' expect to play a leadership role in community health centres - not only to provide technical medical services but to have a say in determining policies and administration of the centre. Practicing physicians fear lay control and changes in payment systems. They would like to have a degree of community involvement clearly specified. They are resistant to changes in the mode of payment from fee-for-service and in the concept of free choice of physicians. Some claim that the concept of a community health centre already exists in well organized practices. However, organized medicine is prepared to encourage experimentation.

The case studies make it clear that physicians presently employed in community clinics are either 'missionary' in their approach and may be inherently different from the normal run of physicians, or university teachers who may have greater commitment to students than patients. Community clinics have not found it easy to recruit physicians.

Dentists are unlikely to be willing to work in any great numbers in community health centres where the presence of auxiliaries is a central feature of the rationalization process. They will be discouraged by prospects of having to delegate work and by new payment systems, and reluctant to accept the leadership of physicians. Dentists appear to value highly the opportunity to perform sophisticated manual skills. Training programs encourage autonomy and independence. The case studies did not indicate much likelihood of change.

Nurses are anxious to be able to use their skills more effectively. International comparisons indicate that their

skills are not being well used. But physicians and patients will have to learn to accept nurses in new roles.

There is considerable ambiguity about the prospect of using social workers in community health centres because of ambiguity about objectives of community health centres. Integration of services is not the same as housing them beneath the same roof. Social workers are not clear about the roles they could/should play. Not surprisingly the other professionals may find it difficult to accept that they have a role.

Other allied health professionals wish to be employed in community health centres. Their struggle for professional recognition and satisfactory pay will need to be recognized and support given to them.

Community health centres ought to become corporate bodies so that nurses and other workers are given proper protection. This new legal status would enable nurses and other health professionals to develop expanded roles.

The fee-for-service system inhibits teamwork because it inhibits delegation by physicians, creates angry feelings on the part of nurses about different payment mechanisms and creates administrative difficulties for business managers who find that they conflict with the doctors over organizational matters.

There are two questions about changing the payment system:

(1) how can it be changed; (2) what should be the timing of change. The professions and public probably have different timetables. Possibly these could be brought closer together by removing some of the uncertainties in career planning of physicians.

The public will not be willing to see doctors paid large sums for delegated work particularly if other health professionals do not get a fair share of rewards. But too rapid change may result in increased emigration of physicians.

Modifications of the present fee-for-service system may be (a) the DIFAM system, (b) sessional payments, (c) contracts of service with fringe benefits, (d) merit payments.

REFERENCES

1. Fish, D.: The Feasibility of Implementing the Community Health Centre Concept.
2. MacFarlane, Bruce and Reid, Angus: The Dentist, Dental Practice and the Community Health Centre.
3. Churchill, Pamela: The Role of the Nurse in Community Health Centres.
4. Kergin, Dorothy: Nursing: Community-Related Personnel, Attitudes and Projects.
5. Splane, Verna: Summary: Nurses' Seminar.
6. Steele, R.: Current Patterns of Primary Health Care Delivery.
7. Greenhill, Stanley: The Distribution of Available Health Care Personnel and Health Resources in Canada.
8. Logan, R. F. L.: Personal communication.
9. Ghan, L.: Social Work Practice in Community Health Centres.
10. Crichton, A.: Summary: Seminar, Allied Health Personnel.
11. Paterson, J. Craig: Summary: Seminar, Legal Issues.
12. Griffith, F.: Problems of an Administrator.
13. Ruderman, Peter: Economic Characteristics of Community Health Centres: Summary and Conclusions.
14. Armstrong, R.A.: Some Observations on Methods of Physician Remuneration in Canada.
15. Boyd, E.A.D.: DIFAM - A New Method of Medical Care Insurance Payment. Medical Care, Vol. V, No. 5, Sept.-Oct., 1967, p. 331-342.
16. Logan, R.F.L.: Personal communication.
17. Southwick A.J. Jr.: The Doctor, the Hospital and the Patient in England. University of Michigan Press, Ann Arbor, 1967.

18. Anderson, D.O.: Personal Communication.
19. Glaser, William A.: Paying the Doctor: Systems of Remuneration and Their Effects. Baltimore, The Johns Hopkins Press, 1970.

TEAMWORK

DOCTOR-PATIENT RELATIONSHIPS

What kind of a relationship between physicians and patients should community health centres attempt to develop?

LeRiche⁽¹⁾ says: "One's general impression is that the public's demands for unmet care are considerably more simple and direct than the needs as seen by the professional administrators. It could well be that the type of health services which would often satisfy the public may be a simple system such as that currently being provided in some of our great cities by medical students in poorer areas of the town". Law et al.⁽²⁾ found that "there is a high degree of satisfaction with medical services even in communities where the investigators thought there would be expressed dissatisfaction...Apparently people get accustomed to the prevailing type of medical and social service they find in their community and they do not complain that this is inadequate because they have no other standard of comparison."

On the other hand, Draper,⁽³⁾ New⁽⁴⁾ and others have described the bewilderment and dissatisfaction of many patients with the processes surrounding the patient-physician consultation. The demands of patients are for a good technical service, given in a well-organized facility, in an atmosphere of courtesy.

Middle-class patients still seem to want a close personal relationship with a physician if they can get it. As well as a good technical service, they want to be reassured, to be able to discuss their problems with someone who can understand their fears. Probably less articulate people would like this too if they could manage to cope with the relationship, but they find communication difficult.

The question which LeRiche raises is an important one because it is concerned with the self-concept of the patient. Is he to become a fully responsible member of a continuing health care team really wanting to look after his health, or is he going to respond only to the urgencies of pain or fear on an emergency basis?

If the patient is to become a member of the continuing care team he will need to be brought into a relationship which allows him to be responsible and to respond.

The demand for a close personal relationship between individual patients and individual physicians may be too expensive for Canada to continue to meet. Yet perhaps one can visualize improvements upon the present impersonal emergency department type of treatment offered in large hospitals.

The patterns of work proposed for community health centres is one which already exists in many group practices. Patients will become patients of the centre, rather than of individual physicians and although they may wish to consult one particular doctor, this will not necessarily be possible and they may have to accept the services which are available and seem to be appropriate to their needs. Patients will need to become accustomed to working with a range of health professionals as well as physician. The concept of family medicine does not mean that all family members will consult one physician but that the health centre will provide a service of primary care to individuals or families, on a continuing basis. This could result in an impersonal bureaucratic service unless special care is taken to focus on people and their problems.

The development of a satisfactory relationship of interdependency is unlikely if the organization of the health team is authoritarian or paramilitary as it is in some departments of hospitals. This is tolerable only when patients are inert or very ill or when their need for help is urgent enough for them to overlook the method of delivery.

Many established physicians seem to work exceedingly hard and yet do not seem to have enough time to give to meet all the personal demands upon them. Many younger physicians are as interested as their contemporaries in other occupations in having a fair share of leisure time.

How then can a personal service be provided other than by teamwork given that the physicians will be working shorter weeks? As in other organizations they will be on shift-work rotas and not available for consultation 24 hours a day including weekends.

THE CHALLENGE TO MEDICAL DOMINANCE

In a paper written for the Project, Evans⁽⁵⁾ says, "The manner in which many of these services are provided and their location would seem to indicate that the convenience of institutions and health purveyors comes first." He believes that while the middle classes are able to adjust, those in lower socioeconomic groups or remote areas find it difficult to obtain satisfactory and convenient access. But, "the consumer is not well qualified to know what he wants or what is the most appropriate type of service and it becomes essential that he be able to develop confidence in the judgment of the purveyors...Without this trust there will be resistance to the health professions...The health system must trend towards a pattern in which 'general physicians' function as co-ordinators of health care services and liaise with other social services on behalf of patients. Such physicians will be increasingly less involved in direct provision of treatment and more towards making diagnoses, based on more complete information. Treatment recommendations will be directed to others who may be either allied health professionals or members of other social agencies, or, in fact, physicians".

There were strong reactions to this view particularly from nurses and social workers who consider that physicians already in power positions are not using their power for the benefit of patients.

The development of teams, "experts in different areas of competence, so that all of their knowledge can be pooled in a unified attack on any problems",⁽⁶⁾ could mean that the physicians' skills are kept for work in which they have special competence and that others take over some of the onerous and time-consuming activities in which they are now involved. Some of the difficulties in defining and developing teams and teamwork were explored in Chapter 3.

In the seminars in which the views of different professional groups towards the development of community health centres were explored⁽⁷⁾ it became clear that there was considerable rivalry for two positions - the role of co-ordinator and the role of receptionist or sorter. Often the discussion of these two roles were confused. The physicians wanted the patients themselves to decide who they would choose to see knowing that most patients, being accustomed to go to physicians, would continue in the same pattern.

On the one hand, the physicians do feel accountable for the quality of work done; on the other hand it is clear that they do not delegate. What most of the professionals seemed to want was to control the flow of patients through the organization and to be involved in the selection and referral processes. None really trusted the others' judgment of sorting out how the clients should be disposed.

SORTING

The development of an improved reliable sorting process is the most vital necessity for making economies in health care delivery. Two groups of people have made specially good cases for becoming sorters:

- (a) members of the local community who may help to guide those who have problems towards the community health centre and so need to be informed about its scope; representatives of this group may be appointed as receptionists at the front door of the centre to steer the people seeking help towards medical or social work services as appropriate
- (b) at a second level, the nurses, who, with a little more training in diagnostic processes, might decide which medical matters need to be referred on to a physician and which they might deal with themselves.

CO-ORDINATING

At the present time there is a considerable amount of misunderstanding about how to develop teamwork appropriate to the technical needs of the patient and how to pass on the patient from one team to another. An important feature in the linkage of work done for the patient in the past was the general knowledge of the family doctor. He knew the family's circumstances, whether there were reliable neighbours or need for visiting nurses. But times have changed.

Weed⁽⁸⁾ has suggested that there should be a new approach to medical record-keeping. The record should focus upon the

patient's problem and by so doing would encourage appropriate co-ordinating actions by the medical care team.

The patients, however, may not be too happy that records are good enough co-ordinators. They may need reassurance and counsel as they move from one part of the organization to another, or between organizations, by someone designated as their personal counsellor. It is this role that the family physicians would like to have - the continuity role - but at the same time they want, like everyone else, to have weekends, holidays, time with their families.

Nurses and business managers also put forward claims to be co-ordinators though clearly these claimants have different concepts of what co-ordination means.

It will be recalled that Alix⁽⁹⁾ suggested the formation of modular teams to deal with specific groups - the elderly, young people, workers, school children - small groups of professional workers, who would have manageable case loads. By breaking down the centres' activities in this way, it would seem likely that good co-ordination with a personal touch could be developed.

However, records will be the key to good co-ordination and it is important to make them readily available for emergency or urgent consultations, as well as to the team giving continuing care.

THE NEED FOR PERSONNEL MANAGEMENT

Sociological studies have shown that when individuals are insecure about their own positions they find it difficult to think about others' needs. That physicians will have insecurities in the face of changes there is no doubt. The allied health professionals are equally uncertain about their future, and consumer boards and indigenous employees will have to learn how to work with the professionals.

All of these may be given more security by becoming members of well-managed organizations, thus the role of the clinic administrator will have to be developed. Presently, most clinic administrators are accountants or business managers with financial skills. It may be as important, or more important to develop their knowledge of social organization so that they may be able to help the staff to find a structure in which they can work comfortably

and give good service. The importance of ensuring that there are good terms and conditions of service goes without saying, but one of the important issues (of which the allied health professional groups made much) is the relativity of rewards and the comparability of terms and conditions of work within the organization. The comparability with outside competitors is also inevitable - the specialists in community clinics have not been happy when they have looked around and compared their rewards with those of specialists in other situations(10).

But clinic managers must preserve the balance between professionals' and consumers' demands. They must ensure that consumers' wants are also made known. Hall(11) suggests that the clinic administrator has another role to play in the capacity of training manager. "It may be the case, then, that the role of the administrator in organizing planning, and directing the work of the community health centre must be expanded to incorporate responsibility for the quality of service provided. If this is the case then the idea of the 'lay' administrator would require further consideration.

CENTRE DEVELOPMENT

The community health centre will wish to train neighbourhood workers to bring local residents into their service whether as employees or volunteers(12). One role, that of receptionist, has already been mentioned but many more can be developed as the work of the centre grows. Voluntary agencies in Canada have developed home-visiting activities and escort roles. Some volunteers have worked as aides in special clinics (well-baby, family planning) and these aide roles could be extended - chaperones in x-ray departments, social work aides, nurses' and physicians' aides. The crisis centre telephone answering services could also be developed. There are possibilities for school outreach and other outreach services. Day care is another activity where helpers are needed. The pressures to involve indigenous workers in the health services have not been as great as those in welfare, although some Indian nurses and health aides have been engaged.

Developments will have to be slow and cautious till new team relationships are gradually tried out and costs assessed.

So far, these new positions have not emerged to any great extent in Canada, though some explorations of new roles in demonstration projects and in community mental health have been made (13) (a), (b).

The development of prepaid group practice and O.E.O. Health Centres in the U.S. has been accompanied by the development of many new types of professional, semi-professional and 'lay' or 'indigenous worker' assistance. Blackman⁽¹⁴⁾ is attempting to analyze the types of new positions which have developed there. His analysis will classify traditional, new and substitutional activities; it will examine the influence of structure-affecting factors, medical-legal constraints, attitudes of physicians and consumers, health manpower resource states, consumer health states, spatial and resource levels, (i.e. mix of physicians and mix of ancillary personnel) and structural elements; the so-called entity elements responsible for administering the unit and the delivery elements which provide the services; professional, semi-professional, technical, administrative and auxiliary personnel. He is hoping to discover the effect of employing these workers on the productivity of the group. Productivity will be examined in terms of (a) activity substitution, (b) co-ordination and communication between the ancillary and physician, and (c) duplication of effort.

NEW STRUCTURES

"Are many of the deficiencies of care that patients suffer from in health institutions more the result of medical professional dominance than of the bureaucratization of such institutions? What devices can be employed to limit the autonomy of the medical profession in the administration of medical care to make that care more responsive to the needs of individual patients?" asks Freidson⁽¹⁵⁾. He argues that the medical profession's special position enables it to control the work of many other interrelated occupations and to govern the layman's access to the help and services these other occupations might provide. Its influence on care is often undesirable. He thinks that "if the health services of the future are to be organized more economically, fairly and 'rationally' than they have been in the past...the patient (must) have direct impact on the care he receives as an individual".

Freidson suggests that even though there are dangers in bureaucracy, it may offer better prospects than professional dominance, for having assessed the evils which may come out of both, he has come to believe that bureaucracy is to be preferred to professional arrogance.

Bureaucracy, in the sociological sense, is a term used to describe organizations which are characterized by (a) a hierarchy of positions which are fairly clearly defined, (b) fixed rewards (usually salaries), (c) positions which are filled by qualified or experienced staff, (d) a set of rules governing the decisions which workers can make.

Bureaucracies may be 'bureaucratic' in the popular sense, rigid and inflexible in interpreting their rules, impersonal and seemingly unfeeling in their dealings with individuals; but they need not necessarily be like this if the individuals working in them are allowed to use their discretion. A number of sociological studies have been concerned with bureaucratic organization. They have drawn attention to such matters as:

- (a) power, authority and influence which stem from technological input, hierarchial organization and personal status⁽¹⁶⁾;
- (b) the implications of technology⁽¹⁷⁾ and size⁽¹⁸⁾ for determining organizational structures;
- (c) the difference in structures of professional service organizations from manufacturing or commercial service organizations⁽¹⁹⁾;
- (d) the struggle to extend domains in order to diminish uncertainty⁽²⁰⁾;
- (e) the difference between co-ordination and integration and the need to develop as much discretion as possible for all participants⁽²¹⁾ ⁽²²⁾;
- (f) the importance of redistributive justice to morale⁽²³⁾.

The findings of these studies suggest:

- (a) that physicians need not fear loss of power since they have power and influence stemming from their technological knowledge and their status. This is probably more significant power than being at the top of a formal authority pyramid;
- (b) (i) that community clinics should differ in structure from hospitals because they are performing a different technical function;
(ii) that there are advantages in very small scale units (personal relationships tend to be good and responses flexible) and in large scale organizations (personnel policies are generous, work is easier to rationalize) and a combination of the advantages of both may be achieved through decentralization;
- (c) professionals are likely to dominate professional service organizations because they are expected to give "normative leadership", to set standards for others involved in the organization;
- (d) but they find it difficult to provide this leadership when the organization is not certain of its prospects of survival, if there is uncertainty they may become less service oriented in their approach, concerned with money-making rather than professional services;
- (e) leadership is more likely to be successful when it can shift away from paternalism, however benevolent, to participant bureaucracy; and followers are likely to respond better if they are allowed optimal discretion;
- (f) all those who are involved in organization have their own concept about their "contract of service"; the more the organization can allow individuals to make discretionary decisions about how to behave, the more likely is the morale of the organization to be high; people have "felt-fair" ideas about income and autonomy - values which may be changed. They will wish to fit them in with those of other reference groups, consequently it is important to make the community clinic itself their most important occupational reference group.

PARTICIPANT BUREAUCRACY

Doctors need not fear that their power will be lessened. They can be generous to other health professionals and consumers because they are and will continue to be so much in demand, but they may have to learn how to relate differently to other health professionals.

That stereotype of bureaucracy, the civil service, tied up with red tape, is not the only form of bureaucracy. Other more adaptive forms have been identified. In these participant bureaucracies, decisions are taken after there has been adequate discussion with all those involved in the organization.

In general, good management is well-organized bureaucratic management and not paternalistic leadership, however benevolent or innovative. Good management should depend upon properly thought through structures and processes.

The structuring of the participant bureaucracy which would be required to replace the present collegial system will be no simple matter. For wherever professionals work in organizations, whether as contractors or employees, they will want to maintain, and where possible improve their position of autonomy.

NEW PROCESSES OF WORKING TOGETHER

Beckhard⁽²⁴⁾ has described the reorganization which took place in one community health centre in the U.S. The model was changed from a functional (hierarchical) structure to a teamwork (problem-centred) structure.

Some of the problems of managing the delivery of the health care as identified by the project director were:

- difficulties in the operation of the health team due to personal, cultural, and professional differences among the members
- problems of information flow and access including record-keeping, transfer of records, etc.

- problems of supervision, particularly first-line
- problems around communications between the health team and the management group of the centre
- problems around the actual workings of the management team at the centre.

"We found that the health centre was operating structurally in a form similar to a hospital structure--that is, basically defined by functions. Reporting to the director of the centre was a medical director in charge of all medical services, an administrative manager, and several staff specialties such as community health advocacy and education and training. All medical service heads reported to the medical director. Their counterparts on the health teams reported to them. The family health workers did not have counterparts on the medical staff so they reported to their public health nurse.

"Some of the consequences of this structure were:

1. Members of the health teams felt removed and alienated from top management.
2. Family health workers had no "home" except their orientation training class composed of the family health workers with whom they had gotten their initial clinical training.
3. Most team members felt that their team meetings which were held weekly with the purpose of co-ordinating work around delivery to their particular patient group were a waste of time. There was little relevant communication between team members around actual health care of their patients. There were communication problems between family health workers and physicians on teams, due to the difference in their backgrounds.
4. The issue of professionalism was important for many people, particularly for some physicians who felt unable to move from the expert-professional practitioner role to one of being a member of the team providing medical service.

5. The reporting structure was relatively unrelated to the work demands. While each team member reported to his functional counterpart, the basic work of the team had to be done by the team.
6. The issue around roles turned on who performed the work and who supported the performance of the basic work. The mission of the centre as defined by its leadership was "to improve total health care to the families in the community." All of this was delivered by members of the health teams who were located structurally at the bottom of the pyramid. The remainder of the organization--administrators, clerical staff, pharmacy, medical service chiefs, personnel, etc., should be a support system for the health teams."

This role relationship between performance and support of performance is almost opposite to the hospital setting where the medical specialties perform the work--patient care--and everyone else supports.

"The early analysis around the dimension of structure indicated clearly that the present structure of the centre was inconsistent with the work to be performed and therefore was inhibiting information flow, decision making, and work effectiveness. A structure more related to the work requirements would need to be developed.

1. Structural reorganization: As a result of the analysis, the entire centre was reorganized. Currently reporting to the centre director is a medical director. The various medical and nurse specialties are in staff roles reporting to the medical director. Reporting to him in a line relationship are unit managers, who are not necessarily M.D.'s, who are responsible for the administrative management of two health teams. All members of health teams, doctors, nurses, family health workers, report to the team unit manager. Other functions such as training, education, health advocacy and administration report directly to the centre director.
2. Role definition: Each health team has re-examined the various roles of its members around the specific tasks to be performed for the patient populations. The roles of heads of services have been redefined and are primarily concerned with development of medical content, planning educational strategies around

that content, and providing consulting and counselling services in the specialties of that role.

3. Decision-making: Unit managers of health teams have full authority for hiring and firing all members of health teams from their own unit. The decisions around treatment and practice are contained within the health team unit. Quality control is against standards set up by heads of service but is managed by the health team.
4. Communication: There are regular meetings between unit managers of health teams and the medical director as well as meetings between unit managers and the various staff specialties around technical problems. The top team also meets regularly with unit managers.
5. Educational and development strategy: The entire training and education program is being re-examined and a number of pieces of content are being taught to the health teams as a unit. Early orientation of family health workers instead of being entirely in a family health worker class, includes field work with teams so that they are being prepared to function as team members. Content in leadership, administration, and group skills has been added to the educational program.
6. The impact of values: Teams are re-examining the problems around different value orientations. For example, in one health team, the family health workers hold weekly meetings in which they "teach" the doctors about the value system and cultural orientation of the patient population in that community.

Although it is difficult to quantify the increased effectiveness of the actual delivery of health care to patients from this effort, there is clear evidence that the energy of those delivering the health care is today much more focused on the work of the centre, the delivery of total health care, and is much less expended on the maintenance of the organization and the relationships of the people who are providing the service. To the degree that the total human energy is available for performing the organization's task, we must assume that the end result will be more effective."

If community health centres are to succeed in developing new forms of medical practice, this kind of restructuring of work will be necessary.

THE CENTRE AND ITS BOARD

Beckhard's analysis of the problems of the staff working in teams suggests that a similar analysis might be applied to the development of relationships between the administrator and board. The administrators' difficulties in working with voluntary boards often seem to stem from inadequate communication and understanding of "line and staff" relationships, roles of board members, what decisions boards should make, keeping up to date with activities of the organization and understanding the values of the professional group.

Consumers will have to learn how they can work with the professionals to improve the system. Anderson and Crichton⁽²⁵⁾ found that the community clinics in Saskatchewan had had great difficulties in getting their group health association boards to recognize the distinction between policy-making and executive activity, and to give the doctors the discretion they needed to have to operate a community clinic⁽²⁶⁾. After nine years one of the group health associations began to turn its attention outwards from the Group Health Association members to look at community needs for health care.

In another treatment centre for mentally disturbed children which Crichton has been studying, there have been many problems of relationship between board and successive directors. These problems stemmed from changes in funding which left the board's authority in great doubt, and from changes in treatment theory which raised important questions about the professional discretion of the director (what was policy-making and what was programming?). This treatment centre evolved from what might be regarded as the prototype of present day group practice - the executive activities were in the hands of a collegial group of three - to a participant bureaucracy. The process took 10 years and is not yet complete but an important step was the shift away from paternal leadership to bureaucratic organization, at first very authoritarian, now much more democratic. The new organizational model permitted the development of teamwork among different

grades of professional and non-professional staff. This suggests that Freidson is right in his observation that bureaucratization may be the most important next stage in the development of the system of medical organization. But there will be great resistances to bureaucratization from the medical profession if the British experience is any indication.

Some delay in implementing effective change is likely to occur unless properly trained administrators who understand organization theory can be persuaded to go into community health centres. It seems unlikely that the objectives of community health centres can be attained unless new structures and new methods of working are planned and implemented and clinic business managers will be in strategically important positions as organizers and mediators in this process. Presently there are too few who are trained.

Are professional administrators in other existing health service institutions likely to be able to cope with this new responsibility? Administrators of hospitals are not really admitted to equal partnership with physicians. Provincial governments have few experienced planners and managers as they have contracted out the responsibility for providing services in the past.

It may be that, given opportunities to develop community health centres, competent administrators will emerge in the next few years, but it will be important to appoint them to work with sponsoring boards from the start, to pay them as much or more than anyone else in the clinic and to give them wide scope.

Griffith⁽²⁷⁾, business manager of one of the group health centres in Canada listed "the power points" which he saw in his organization.

- (i) "Those arising from internal organization:
 - (a) voluntary lay board
 - (b) medical group
 - (c) employees
 - 1. professional and technical associations
 - 2. unionization of some staff
 - 3. committees and action interests
 - (d) women's auxiliary
 - (e) faculty or educational involvements
 - (f) research interests

- (g) board and medical group committee
 - (h) administration
- (ii) Those arising from external organizations:
- (a) governments at all levels in all roles
 - (b) programs of accreditation of whole facilities or departments
 - (c) personnel mechanisms - licensure
- credentials
 - (d) other consumer organizations
 - 1. labour union groups
 - 2. consumer groups- especially with health care orientation
 - 3. neighbourhood groups
 - 4. political groups
 - 5. women's liberation, etc.
 - (e) co-ordinating agencies
 - 1. health units
 - 2. welfare councils
 - 3. regional health planning bodies
 - (f) other health care agencies
 - 1. medical societies
 - 2. voluntary agencies
 - 3. hospitals
- (iii) Those arising from unorganized external forces (sic)
- (a) traditions, folkways and mores in medical care, community, etc.
 - (b) legal barriers
 - (c) economic forces
 - (d) social forces
 - (e) scientific developments
 - (f) marketing pressures
 - (g) patrons, sponsors
 - (h) race and ethnic factors"

If the administrators are to deal with all of these matters and to deal with them well, then this job will have to be given very special consideration by governments that wish to bring about change.

SUMMARY

What kind of doctor-patient relationship is needed?

Groups who have never had a service may be content with an emergency-room type service, but the middle classes have become used to a personal relationship with physicians. This kind of relationship is unlikely to continue as doctors want to have leisure too. Teamwork will provide an answer particularly if the patient is made a responsible member of the team. Teamwork will also enable the centre to be manned over long hours.

Doctors expect to have leadership roles and the public supports this. Doctors believe they are the only one who can make effective decisions.

Nurses are anxious to have the opportunities which community health centres would offer to expand their roles. Nurses' skills are presently underused in Canada.

Many professional groups want the role of sorting out patients' needs and guiding them to the right professional help. There are two levels of sorting-arranging to meet general needs and arranging to meet needs for medical help. Indigenous workers might do the former, nurses the latter.

In the past the family doctor was the co-ordinator. Now co-ordinating can be done by keeping problem-oriented records but there is also need for personal attention. Breakdown of personnel into small teams could help to maintain this personal interest.

There is need for good personnel management in a community health centre. Since many workers will need reassurance, attention should be paid to terms and conditions of employment. Rates should be relative within the centre and comparative with other jobs outside.

A community health centre should try to develop local workers. There are many jobs which they could do. A study of substitution activities is being made by Blackman.

New organization structures will need to be developed. A participant bureaucracy might replace the collegial relationship of physicians, a relationship from which support staff are excluded.

Beckhard reports on what this change in approach meant to a U.S. health centre. The centre developed problem-oriented activities which necessitated a completely different form of organization from the hospital model. Analysis led to (a) structural reorganization, (b) role redefinitions, (c) changes in decision making, (d) improved communication, (e) development of an educational and development strategy and, (f) consideration of impact values. After the restructuring of the organization there was less concern about relating to others, more interest in problem-solving.

It will be important to develop the role of professional administrators, if community health centres are to develop satisfactory organizational structures.

REFERENCES

1. LeRiche, H.: Unmet Medical Needs.
2. Law, M. et al.: Changes in the Use of Health Services and in the Population Health Status with the Formation of a District Health Unit. Part I - Baseline Survey, Department of Community Health and Epidemiology, Queen's University, Kingston, Ontario, 1971.
3. Draper, M.: How Can the Quality of Ambulatory Health Care be Improved?
4. New, Peter K.: The Relationship of Emergency Services and Community Health Centres: One Perspective.
5. Evans, George: Community Health Care: Manpower Considerations.
6. New, Peter K.: An Analysis of the Concept of Teamwork. Community Mental Health J., Vol. 4 (4) 1968.
7. Summaries of Manpower Seminars, Feb. 21-Feb. 29, 1972.
Greenhill, Stanley: Physicians
Splane, Verna Huffman: Nurses
Crichton, Anne: Allied Health Professionals
Hlynka, J. N.: Pharmacists
Hunt, Murray: Dentists
Mackenzie, John A.: Social Workers
Crichton, Anne: Managers and Administrators
8. Weed, L. L.: Medical Records that Guide and Teach, New Eng. J. Med. 278.11, 2 parts, March 14 and 21, 1969.
9. Alix, Jean-Pierre: Problèmes de Définition et d'adaptation. Le Centre Local de Santé.
10. Ghan, L. and Road, D.: Social Work in a Mixed Group Practice. Canad. J. Public Health, Vol. 71, Nov-Dec. 1970. p.488.
11. Hall, Oswald: Allied Health Personnel in Community Health Centres.

12. McPhee, Jean: Native People Learn to Help Themselves, Canada's Health and Welfare, D.N.H.W. Vol. 26, No.2., Ottawa, 1972.
13. (a) Canada, D.N.H.W. Research Projects 1970-71, Ottawa.
(b) (CELDIC) Report: The Commission on Emotional and Learning disorders in Children: One Million Children. L. Crainford, Toronto, June 1970.
14. Blackman, A.M.: Structural Elements - Use of Ancillary. - mimeographed - University of Michigan, Ann Arbor, 1971.
15. Freidson, Eliot: Professional Dominance: The Social Structure of Medical Care. Atherton Press, Inc., New York, 1970.
16. Dubin, R.: The World of Work. Prentice Hall, Englewood Cliffs, 1958.
17. Woodward, Joan: Industrial Organizations - Theory and Practice. Oxford University Press, Oxford, 1965.
18. Bendix, Reinhard: Work and Autonomy in Industry. McGraw Hill, New York, 1956.
19. Etzioni, Amitai: A Comparative Analysis of Complex Organizations. Free Press, 1961.
20. Thompson, W.D.: Organizations in Action. McGraw Hill, N.Y., 1968.
21. Gouldner, A.W.: Patterns of Industrial Bureaucracy. Routledge and Kegan Paul, London, 1955.
22. Baldamus, W.: Efficiency and Effort. Tavistock, London, 1961.
23. Runciman, W. G.: Relative Deprivation and Social Justice. Routledge and Kegan Paul, London, 1966.
24. Beckhard, Richard: The Management of Team Delivery of Comprehensive Health Care. mimeographed - presented at the Joint Scientific Session of the Association of Teachers of Preventive Medicine and the American College of Preventive Medicine, Minneapolis, Oct. 10, 1971.

25. Anderson, D.O. and Crichton: Economies of Group Practice in Saskatchewan. unpublished manuscript. University of B.C., 1972.
26. (a) Crossman, L. G. and Rands, S.: Citizen Involvement in Community Clinics.
(b) Lee, Dorothy, M.: The Role of the Trade Union at the Regina Community Health Clinic.
(c) Road, David A.: The Difficulties of Establishing a Community Health Centre.
27. Griffith, F.E.: Problems of an Administrator.

GETTING VALUE FOR MONEY: EVALUATION OF SERVICES

FOUR KINDS OF ASSESSMENT

A nation's health and welfare services may be evaluated by the tried and traditional methods of waiting for public opinion to be expressed, by using consultants to advise on standards, by using managerial techniques or by scientific evaluation. In practice, most nations use a combination of these methods.

Caro⁽¹⁾ says that interest in evaluation research is likely to be greatest when there is a predisposition towards gradual change. It does not interest conservatives or revolutionaries who both have their ideologies. "Emphasis upon evaluative research is most appropriate," he says, "where it is to be expected that program effects will not be directly and immediately evident" e.g. large scale education, welfare and social service programs where effects are subtle and diffuse, and where there is greater distance between providers and consumers.

"A heavy investment in formal evaluation is most likely to be justified where a program is expensive, its impact is potentially great but uncertain and where the potential for diffusing programming concepts is great..."

It may be useful to consider the traditional methods of assessment and the new techniques which may be more appropriate for studying the impact of community health centres.

INVESTIGATION THROUGH PARLIAMENTARY MECHANISM

Traditionally, through the democratic processes of letters to the editor, radio and T.V. discussions, parliamentary questions and pressure group activities, governments are made aware of public opinion about their legislative and administrative actions. As the need for action becomes more obvious they may decide to test public opinion further by publishing White Papers for discussion. In more complex and controversial situations, a Royal Commission of independent investigators may be asked to prepare

a report. Reaction to White Papers and Royal Commission Reports will indicate whether the government should proceed to legislation. In Great Britain, there is yet another mechanism which does not seem to have an exact counterpart in Canada - the departmental committee. Ad hoc departmental committees, composed of interested laymen and professional experts, are appointed for the purpose of indicating new directions to the government department which wishes to make some administrative changes in the organization of public services. The Hastings Committee is not unlike a British departmental committee except that it was not funded directly and provided with a government secretariat but was supported by a National Health Grant and employed its own staff.

CONSULTANCY

In Canada, particularly in the hospital service, development of consultancy both from voluntary and government sources has been considerable. One example is Saskatchewan which has five Regional Hospital Councils employing consultants in accountancy, medical records, social work. The Saskatchewan Hospital Association also employs consultant nurses and dietitians and negotiates on behalf of the hospitals with employee groups; the Saskatchewan Hospital Services Plan employs a medical consultant. There are also consultants in rehabilitation attached to the public health service of the province. In British Columbia, the Hospital Insurance Commission has developed an industrial engineering department which makes work studies on special problems e.g. the location and standardization of chronic renal care units and the public health service has set up an operational research department. In Quebec, the regions have had planning divisions, now disbanded under Law 48.

However, some problems relating to the system of provincial contracting with independent agencies exist. One is the extent of the consultants' authority, which, if ill-defined, may create strains in the organization. There is need for clarification of mutual expectations at an early stage. These may not always be easy to determine when the organization itself is not clear about its objectives and when the sources of power are divided i.e. between funding agencies and professional disciplinary bodies.

Consultants can make many useful contributions both at the design stage (planning of staffing, program development, siting of buildings, architectural style and building techniques, equipment) and at the operational stage. The problem is related to their authority. In Britain and the U.S. there have recently been scandals about chronic care hospitals and a monitoring system has had to be developed against the resistance of the medical profession.

Maddox⁽²⁾ has suggested that by using these two mechanisms of parliamentary discussion and consultancy judiciously, and by following a policy of slowly negotiated changes the British National Health Service and the interlocked social services have been able to adapt to new ideas gradually and successfully since the legislation setting up the 'welfare state' was introduced. He thinks the British public has had good value for money and he questions whether rational investigation would have produced better results.

MANAGEMENT TECHNIQUES

Klein⁽³⁾ confirms that there is little general interest in 'consumer involvement' in Britain, but there is a growing interest in measurement of results within the overall ideological commitment to provide health services.

(a) Program Review

A management systems approach is now being introduced in the U.K. This type of evaluation is described by Beaudoin⁽⁴⁾ as being an appropriate approach to the assessment of social welfare services in Canada. He suggests that evaluation should begin with a listing of existing programs and an examination of their scope, for a whole series of programs might be collapsed into one extensively reorganized scheme able to tackle a whole range of social problems. He considers that it is important to scrutinize present program objectives, administrative structures, physical and financial resources. Particularly in the social welfare services there is need to move beyond ideological commitments to properly costed and evaluated global programs. "When they are able to make adequate evaluations of their work, social workers will gain much more power to achieve their objectives."

It seems clear that many provincial governments need to begin with program review. At the present time most governments contract work out to voluntary agencies. The controls over them are not well developed for each is jealous of its autonomy and machinery exists to help to maintain this e.g. accreditation procedures. For example, it is obvious that there could be a considerable amount of rationalization of hospitals.

Apart from program review, the other managerial techniques of assessment that may be used are cost-benefit or cost-effectiveness analyses and operational research. The importance of all these techniques lies in the necessity, which they impose, of clarifying objectives, determining priorities and balancing organizational choices.

(b) Cost-benefit or cost-effectiveness analyses

Some mention was made by Klein(5) of the advantages and disadvantages of cost benefit analyses - they tend to focus attention upon quantifiable data and to underestimate other factors. Beaudoin also mentions the technique of rationalizing budgetary choices which is based on an elaboration of information systems used for budgetary decision-making.

(c) Operational research

Operational research may develop simulation techniques for problem analysis and problem solving, or it may be used, as in Scotland, for reviewing on-going programs (such as the development of health centres) and assisting their adjustment to evolving concepts of teamwork and health care. (6)

It would appear to be particularly important to develop these managerial techniques for the health services as rapidly as is feasible so that regional programs may be streamlined with as little waste as possible.

Baudoin points to three stages in the development of programs: "l'étape d'initiation, la phase de contact,

l'étape d'implémentation."* Each of these stages needs to be evaluated. There are five steps in social program evaluation he says:

1. systematic accumulation of facts,
2. review efforts made, efficacy attained and productivity achieved,
3. differentiate these three activities,
4. use technical methods (e.g. program review, social scientific research methods, cost analysis and operational research),
5. recognize cultural context and its value system.

SCIENTIFIC EVALUATION

The fourth approach 'scientific evaluation' is described by Caro as being quite different from basic research. Some, he says, consider it to be distinctively different, others classify evaluation as a form of research, differing in purpose rather than method. He cites Cherns⁽⁸⁾ who distinguished the difference by saying that basic research arises out of perceived needs of an academic discipline whereas action (evaluative) research is concerned with an ongoing problem in an organizational framework and involves the introduction and observation of planned change. They differ too in potentiality for utilization: basic research has greater potentiality for generality but is limited for immediate utilization, the opposite is true of evaluative research.

Reviewing the issues in the evaluation of social programs, Caro says: "Attempts to define evaluation reflect concern with both information on the outcomes of programs and judgments regarding the desirability or value of programs. Several distinctly different approaches to evaluation methodology may be identified. Legislators, administrators, practitioners, recipients of service and journalists are among those who typically rely on impressionistic or informal evaluation. Stake⁽⁹⁾ has described informal evaluation as dependent on casual observation, implicit goals,

* c.f. Anderson,⁽⁷⁾ who describes three aspects of research: development, research and demonstration.

intuitive norms and subjective judgment. He characterized informal evaluation as of variable quality - sometimes penetrating and insightful, sometimes superficial and distorted. Similarly, Mann and Likert⁽¹⁰⁾ noted that observations of participants may provide suggestive leads for interpreting the effects of programs, but because the extent of their bias is unknown, it is impossible to judge the accuracy of their conclusions.

"Among formal approaches to evaluation, a distinction may be made between those emphasizing inputs and outputs. Educational accrediting agencies, municipal building inspectors, and fire insurance underwriters engage in formal evaluation activities using explicit check lists and formulas. Their evaluative judgments are based on inputs. Data are typically obtained through site inspections." Glass⁽¹¹⁾ pointed out that... "this approach is weak in the areas of objectivity and validity. The program accounting approach to evaluation also emphasizes inputs or efforts. Its focus is on the maintenance and quantitative analysis of records of project activities. The extent of actual practitioner-client contact or the number of clients exposed to programs are typical concerns. Outputs or effects tend to receive little attention because program accounting is tied to routine agency records, and agencies are usually unable to undertake the extensive follow-up activities that would yield complete information on the outcome of services. Program accounting is useful as a procedure for determining the administrative viability of programs. It may provide a sound basis for screening programs on the basis of ability to establish contacts with clients and the cost of program-client contacts."

Evaluative research, says Caro, is characterized by its emphasis on outputs or effects and its concern with the use of the scientific method. The emphasis in evaluative research on outputs need not imply a lack of concern over input variables.

"Evaluation may be viewed as a phase in systematic program development. Ideally, action programming is preceded by a planning process that includes (1) identification of problems; (2) specification of objectives; (3) analysis of the causes of problems and the shortcomings of existing programs, and (4) an examination of possible action alternatives. Evaluation follows program implementation and provides a basis for further planning and program refinement...The planning, action, evaluation cycle

may be repeated indefinitely until objectives are realized or programs and objectives are redefined. Results of evaluation may be used to modify programs when they are in progress and to increase the likelihood of realization of long-term goals. When evaluation is viewed as part of a process of planned change, the utilization of evaluation findings in decision making becomes a key concern."

Evaluation, he says, may be "formative" or "summative" according to the stage of development of the organization being reviewed.

Caro ends his review by saying: "Evaluative research is an activity surrounded by serious obstacles. Satisfied with informal and impressionistic approaches to evaluation, policy makers are often reluctant to make the investment needed to obtain verifiable data on the effects of their programs. Evaluative researchers are typically confronted with problems of measurement and design which greatly restrict their ability to reach unambiguous conclusions. Abrasive relations with practitioners and clients can add to the evaluators' difficulties in obtaining information. Evaluative research is often addressed to a distressingly narrow range of issues and results are not as fully or widely disclosed as they might be. At the same time, highly pertinent findings of evaluative research are often ignored by policy makers. It is little wonder that many social scientists regard evaluative research as a dubious enterprise.

"Yet the argument for emphasizing evaluative research in social programming is strong. Expenditures...are enormous. At the same time there is reason to be dissatisfied with the effectiveness of many of these programs. Increase in programming costs tend to be much more conspicuous than improvements in the quality of services. If it can be agreed that social programs should be strengthened and that improvement is most likely to come about through the use of rational methods, it is clear that the evaluation role is important and should be emphasized. If there were a more serious emphasis on performance standards and a search for more effective program approaches, evaluation researchers would be more often able to obtain the political and administrative support needed to employ powerful experimental designs. (There is a need then to be concerned) not only with immediate methodological and organizational problems but the larger issues concerning the social context in which social programs are conducted."

MEDICAL RECORDS

A basic requirement for scientific evidence is a data base. Morgan (12) has suggested that the problems of medical record keeping are problems in decision-making:

- "What information should be collected?
- What data should be recorded?
- In what format should data be entered?
- How should records be filed?
- How should data be retrieved?"

These questions, he says, are basic. "The answers depend upon: The purposes of data collection; the data sources (reports, various personnel, etc.) facilities available (personnel, hardware, software); individual enthusiasm, outside assistance (advice) or needs (requests)..In designing a record system for an ambulatory care facility, there must be a clear a priori understanding of: the objectives of the record system, the priorities of the objectives, data sources - quantitative and qualitative; resources, including constraints; issues of privacy and ethics. The main objectives of the records are: to assist in continuing patient treatment; to protect the physician and his agents, to assist in administration, especially billing, to provide research material; to assist in evaluation of quality of care." Two reviewers have been unhappy "that quality of care" comes so low in Morgan's list. One suggests that it is part of the same concept as "continuing patient treatment."

Morgan suggests that "in the view of most practicing physicians, the record exists for their convenience and use in treating the patient. Other considerations, such as legal and administrative implications, play a minor part in design or use of the record. There may be some difficulty in persuading community health centre physicians to really expand the usefulness of the record. There will be a natural reluctance to provide research material if it increases the physicians' work; most research projects involving extra work for the practitioner fail miserably no matter how enthused the participants seem initially."

* An international conference on ambulatory care records was held in Chicago in March 1972 and a report on the proceedings of the conference should be available shortly. Possibly this will enable standards to be set for community health centres and may recommend audit procedures. (13)

In hospitals, doctors have become accustomed to the system of medical audit. These records are kept in a central file by medical record librarians or technicians who are required to use them as a basis for reporting on the hospital's work for accreditation purposes. Morgan believes that a doctor will tolerate hospital audits "because of the substantial fear of loss of admitting privileges; but he may balk at invasion of his heretofore private writings. And, unlike hospital records, there are almost no widely accepted standards (empirical or normative) of ambulatory care records." He considers that the physicians will have to be offered some return for the extra work and loss of privacy. He says: "While a few may respond to the system for its educational feedback, more likely most will accept it only if it is enforced as a condition of pay/employment/continuing accreditation in a professional organization. As well, the purpose of the audit must be clear to all: Is it to monitor quality, educate the physician or provide research data?"

Hewitt⁽¹⁴⁾ takes a somewhat different view from Morgan. Writing about community health centre records, he says: "It is almost within the definition of group practice that participating physicians and other staff will compile and use records jointly. By comparison with the solo practice situation, then, one may note: (a) that when professional responsibilities are shared, personal recollection cannot possibly suffice, and for the first time (but as in hospital work) a patient record becomes the indispensable basis for continuing services; (b) that joint use of records constitutes a natural basis for perpetual mutual quality audit." He believes that there is a difference between the mental set of the solo practitioner and the group practitioner "the former resents intrusion on his (not the patient's) privacy and has little relevance to group practice." The question then which arises is the extent to which teamwork can be developed, for teamwork is problem centred and should eliminate the difficulties of opening up records to scrutiny.

SIMPLIFICATION AND STANDARDIZATION OF RECORDS

Morgan concludes his paper with a discussion of record simplification which he believes to be a necessity if records are to be used as a research tool. He would like to see more use

of computerization which would require simplified recording and, he believes, more effective recording.

It is clear that record systems for community health centres need to be carefully thought out. There are many other problems which were noted in the Saskatchewan group practice study, e.g. the difficulty of keeping family records together.⁽¹⁵⁾

One question which is brought up is the question of record standardization in all community clinics. If this could be achieved there would be tremendous advantages, particularly if it were linked to a life history record of the patient. Morgan is dubious about introducing either of these quickly though others have been more confident about the possibilities.

CONFIDENTIALITY

Morgan also raises, but does not discuss in any detail, the question of confidentiality of medical records. This becomes an even more difficult question if these become health records and combine medical and social factors. Wallace and Davis⁽¹⁶⁾ believe that computerization may protect the patients better because access to computerized records will be easier to restrict. "If card punching is performed outside the medical centre, the operator is supplied solely with a list of codes which are meaningless without the code chart." Williams⁽¹⁷⁾ is not so sure. In a recent article, he has discussed the effect of teamwork upon record keeping. He draws attention to the need for records to circulate "on a horizontal plane (where) the health professions are divided by training, responsibility, power and prestige into the occupational categories of technicians, nurses, other allied health professionals and physicians..and on the vertical plane (where) the health professions are divided by clinic departments and specialties. The departments are limited in knowledge and practice to particular components of the health processes. The resulting mosaic results in a series of boundaries which vary in permeability for the health professions. Yet a particular patient with a particular set of health problems can move through (these).. As a result health services tend to be fragmented and impersonal as each health professional explores his assigned segment of the case...The unifying elements are the medical record and the accounting statements...Patients are required to disclose

confidential information to an indeterminate number of health professionals either verbally or through clinical, laboratory, psychiatric exams or intensive interviews. In addition to the patient's chart, each profession keeps its own records." Williams lists nine purposes for keeping records: basic accounting procedures, classification of records by problem areas, diagnosis and clinical interpretations, case history, treatment, case registry (e.g. cancer cases), record linkage, control, research. He goes on to discuss the need to protect the privacy of information given in confidence whilst at the same time providing the data required for social planning and social control. Presently, he says, "minimal attention has been given to protecting privacy and confidentiality of health records. Accurate and inaccurate health information is being disseminated to a wide variety of agents who are using it against some individuals." He suggests that more controls over dissemination of information are urgently required, so that researchers may be freed to do their work properly.

EVALUATION OF AMBULATORY HEALTH CARE: THE EPIDEMIOLOGISTS' VIEW

Buck⁽¹⁹⁾ thinks that a health care facility should develop methods for educating its clientele not only to comply with treatment but also to seek treatment and to attend for preventive and detection procedures of established worth.

She asks: "Should a system of health care include the 'recruitment' of persons with health problems amenable to care?... If so, it would be necessary to identify the clientele of a particular health facility in order to determine whether appropriate forms of 'recruitment' had been attempted. It will be recalled that LeRiche^(20a) did not think that this was necessary since most Canadians seem to be willing to go in search of health care when they want it. However, Sackett^(20b) suggests that consumers do not know how to make good use of diagnostic and treatment services under the present conditions of delivery. The question of enrolment of patients within a free-choice system has already been discussed but neither Buck nor Sackett mentions the free-choice principle.

It has been suggested that one of the advantages of a community health centre would be its concern for surveillance,

maintenance and restoration - the continuing care of patients - and whether to provide an elaborate system of medical screening will therefore be an important question to answer.

Epidemiologists are specially interested in the question of diagnostic screening. This is an area of intense controversy and one on which cost benefit research is urgently needed. Pearson⁽¹⁸⁾ has reviewed the evidence and develops a concept of "critical morbidity" i.e. that screening must be restricted to those conditions in which it is possible to affect the natural history of the disease. Screening procedures are found generally warranted in matters concerning ante-natal/post-natal care, children, pre-employment and armed forces induction. In such cases, screening is directed at physical, emotional, behavioural and learning problems. Where a screening program is part of a comprehensive care system which includes surveillance, preventive, curative services and an integrated record system "the virtues of screening may be fully exploited." Without proper follow-up screening is not useful.

In a widely cited review of methods of evaluation of the quality of medical care, Donabedian⁽²¹⁾ suggests that there are three approaches to the assessment of care: the examination of outcomes, of processes, of the settings in which it takes place and the instrumentalities of which it is the product. "This (last) may be roughly designated as the assessment of structure although it may include administrative and related processes that support and direct the provision of care." But..."the relationship between structure and process or structure and outcome is often not well established."

Buck goes on to examine structures, processes and outcomes. "Whenever structure can be used as an indicator of quality it should be. Probably we can identify some physical aspects of structure whose relationship to the quality of care is undeniable. We are on much less certain ground when it comes to the administrative aspects of structure."

She says: "As far as process is concerned the major difficulty is the frequently uncertain relationship between process and outcome. This is not just a matter of the varying degrees of compliance on the part of the patients. Quite a number of diagnostic techniques and therapies are of unproven utility in terms of outcome"...More is known about the use of drugs and other therapeutic techniques than about the processes of

diagnosis. "The study of process can be used to measure quality of care only to the extent that process has been validated." She believes that the record system of a health care facility must become one of the criteria for the assessment of quality.

In discussing outcomes, Buck says that it is only in certain circumstances that outcomes can be more easily measured than processes, e.g. in vital statistics of mortality and morbidity, but these are too remote from the unit of delivery. However, she believes it would be possible to pull out morbidity data from records kept for billing purposes, provided that physicians are recording true diagnoses, not "allowable" diagnoses (distortion occurs when payment schedules are out-of-line). This cannot be done in a capitation system and "an important source of routine information about health outcomes" may be lost unless it is given consideration. Logan(22) suggests there are other ways of overcoming this lack, by case sampling on given days, but one of the virtues of the fee-for-service system has been its detailed data collection. "If quality control is to become a reality, good records are necessary for the examination of outcomes, processes and clientele, and to assess the state of knowledge and process-outcome and structure-outcome relationships and to establish a means for relating process records to health outcome records."

Sackett suggests that the key question is: "Which health professions should deliver what ambulatory services to which members of the community?"

"The planning and evaluation of innovative ambulatory care programs, if based upon determinations of the extent to which the recommendations of the health professions and the more specific service demands of the general community have been carried out, carries with it no guarantee that the health services will be of health benefit to the community. Similarly, efficiency maximizing evaluative techniques presuppose the health value of the services being optimised. (But this is inadequate)...for evaluation to be successful two contrary forces must be recognized and a middle group identified". First evaluation must be identified as a serious goal, second, the evaluation undertaken must be both relevant and feasible in the local community setting. It must focus upon key issues of greatest relevance to that setting and must use the scarce evaluators well. Sackett believes this middle ground to lie "in an evaluation which focuses upon a study of whether the program makes available

those services previously demonstrated to be beneficial to health, coupled with a limited investigation of the acceptability of health professions in new and expanded roles." He goes on to outline a method which has been used for training health evaluators in Canada. He lists a series of questions concerning efficacy, effectiveness, availability, and efficiency and suggests technical methods of dealing with these questions.

EVALUATION OF COMMUNITY HEALTH CENTRES: THE SOCIOLOGISTS' VIEW

The sociologists are less interested in outcomes than in processes and structures. In the past, interest in process was a medical professional interest in efficiency and effectiveness. Now, Draper⁽²³⁾ suggests, processes should be evaluated through the eyes of consumers also and not only those of physicians. There are other ways, too, of evaluating structures than those described by Buck⁽¹⁹⁾.

One example of the sociologists' approach was that used in collecting case study material on health centres⁽²⁴⁾. The guidelines sent out to correspondents asked for reports to be written under these headings:

"The case material to be collected can be grouped under four headings:

1. Conception: The idea or the philosophy of the health centre; favourable or unfavourable political forces; problems and their solutions, etc.
2. Program: The centre itself; the services, personnel, methods of beginning, the relationships; the cycle; plans of operation, stabilization, etc.
3. Population: Socioeconomic levels, health levels, social and political organization, etc.
4. Effects: Frequency of access to the clinic; attainment of health levels; effects on the global politics of health, etc.

Each of the above headings affect the others in ways so that the whole constitutes a dynamic process. Analysis of this

process can be very complicated; it is this feedback which will permit us to explain the diverse qualities of particular programs (in our case, the health centres), especially their evolution.

The type and direction of these effects on the population:

- on the levels of individual attitudes; e.g., Are the citizens more or less disposed toward medicine? Do the citizens have the impression of being treated more humanely?
- on the levels of involvement; e.g., Do citizens consult doctors more often?
- on the levels of health; e.g., Is the rate of infant mortality effectively lowered? Is there any correspondence between the services offered and the health problems of the population?

In effect, we pose some broad evaluative questions regarding the program where information is available and where we can, through time, note these effects.

THE FUNDING OF RESEARCH IN THE U.S. AND CANADA

The major disciplines which may be applied to analysis of health services organization are epidemiology, sociology and economics.* Anderson(7) is concerned about the way in which granting committees tend to be dominated by epidemiologists. Reviewing the reasons why applications for research grants fail to get funded, he says that many fail the test of peer review because they are judged on epidemiological criteria. They are judged to have failed the test because: "There is no hypothesis, no concept of denominators, an inappropriate attempt to generalize to a broader population, misuse of statistics, failure to consider clinical trial design, too small a sample, too many variables (one runs out of what the statistician calls degrees of freedom) and so on and so on down the whole path of

* The contribution of the health economists is discussed in a separate paper by Dr. Peter Ruderman(25).

epidemiological clichés." If health centres are to be evaluated, the researchers' grant applications are not likely to be able to meet basic research criteria. They will be concerned with "an on-going problem in an organizational framework including the introduction and observation of planned change."

In a critical review of U.S. health care grants in 1970, it was found that only 32% of applications were approved; "staff have noted that if there was neither a biostatistician nor an epidemiologist associated with the grant proposal the approval rate was only 23%, if there was either a statistician or an epidemiologist, it rose to 43%, if there was only an epidemiologist it rose to 60% and if there were both, to 67%." But Anderson does not tell us how many epidemiologists or statisticians and how many economists or sociologists acted as peer reviewers.

He has drawn attention to the changing patterns of funding of U.S. research in health care, reported in September 1971 by the National Centre for Health Services Research and Development. The centre was established in 1969 with four divisions; community health services, research and development technology, social and economic analysis and training (grants).⁽²⁶⁾

The research and development division is concerned with demonstration projects "to assist selected communities to develop economically and medically sound health care delivery patterns to serve their total populations....A fundamental prerequisite is the existence of an organization representing all major health-interested groups in the community, including consumers, providers, third-party payers and appropriate political institutions" and with other experiments in health services planning and delivery systems.

In the technological division, several medical organizations are being supported in reviews of more effective experiments in developing patient care:

1. Developing and refining of procedure and treatment criteria for the office care of patients.
2. Effectiveness of hospital and ambulatory care.
3. Assessment of hospital care provided by internists.
4. Prognostic epidemiology.
5. Review of claims and content of medical practice.
6. Pediatric care review.

It is also concerned with health services data systems:

1. Hospital information and medical data processing systems.
2. Community medicine information systems.
3. Health maintenance through disease detection and screening.
4. Logistics of health care delivery.

The social and economic analysis division has four branches- economic analysis, epidemiology, political and legal analyses, and social analysis. In economic analysis, the branch is concerned with analyzing the supply and demand for health services and possibilities for removing obstacles to the optimal allocation of resources for health. Current interests are: incentives, payment systems and insurance, economic organization of the health care industry, supply, and demand for health care, and manpower. The political and legal analyses branch is interested in analysis of political and legal processes as they impinge on health care. The social analysis branch was set up to try to understand the dynamics of the interrelationship between providers and consumers of health care in specific organizational settings in which care is provided and the variables which impinge upon this interaction. Major interest centres upon (1) consumer behaviour, (2) professional behaviour, (3) organizational behaviour, (4) community behaviour, and (5) methodological issues in data gathering.

This division emphasizes its multidisciplinary approach. Of special interest are the manpower demonstration projects which have been funded.

1. Mid-level medical workers; physicians' assistant, family nurse practitioner, pediatric nurse practitioner, school nurse practitioner, nurse midwife, dental auxiliary.
2. Appraisal of medical clinic staffing patterns.
3. Allied health management of chronic diseases.

Chart 15 gives information about the main topics of research in health care funded in Canada in 1970⁽²⁷⁾. The same problems that have existed in the U.S. about peer judgment apply in Canada. National Health Grants Committees have been dominated by economists, epidemiologists and statisticians though recently

representatives of other disciplines have been appointed as members. There are now sub-committees for considering basic and demonstration grant applications.

However, sociological research needs to be encouraged. Grants are unlikely to be awarded for the study of the emergent stages of clinic development on present criteria. Presently a grant application would probably require the centre to have established a medical records system for the study of its patient population and this does not become available until the centre is well established. The sociologist can develop baselines long before a centre begins to be established in a community. His interest is in "before and after" studies other than in populations.

THE SPONSORSHIP OF EVALUATION

"Because of problems of cost and access to information, formal evaluation is usually a sponsored activity. The issues addressed by evaluation and the manner in which the results are reported are strongly related to sponsorship. Consequently, the interests of the general public, practitioners, and recipients of services are not often fully served by evaluators," says Caro.

In a letter to the research co-ordinator of the community health centre project, Anderson⁽²⁸⁾ pointed out that studies made without effective political support and without the involvement of politicians or professional power groups who can implement change are likely to founder. He uses as an example research on health care problems in British Columbia, where the difficulty has been that the fruits of the research have not been used to effect changes. The medical profession has resisted the efforts of the B.C. Health Resources Council to co-ordinate manpower planning in the province. He suggests that "neither demonstration projects, nor research projects will be of any value unless they:

1. are sponsored by bodies which have power to implement change,
2. are developed to answer questions posed originally by the change agents,
3. report back to the change agents,
4. include specific recommendations relevant to appropriate and feasible change."

Chart 15

TYPES OF RESEARCH FUNDED BY HEALTH CARE GRANTS IN CANADA 1971

Section A:	<u>Quality of Health Care</u>	<u>Quality of Environment</u>
	Maternal, infant	Air Pollution
	Children	Radiation
	Mental Health	Sewage
	Nursing	Chemical Pollution
	Genetic	Water
	Infection	Noise
	General	General
Section B:	<u>People in Health Care</u>	<u>Manpower</u>
	<u>Education</u>	
	Continuing	Academic
	Medical	Practicing
	Nursing	Nursing
	Nurse Practitioner	Dental
	Trials	Paramedical
	Paramedical	General
	Public	Expectation
Section C:	<u>Organization of Health Care</u>	<u>Family Practice Units</u>
	<u>Clinics</u>	<u>Organizational Studies in</u>
	Youth and Drug	Medical Practice
	Underserviced Areas	Regionalization
	Miscellaneous	
	Student	
	Community	
	Mental Health	<u>Evaluation</u>
	Nursing	Mental Health
	Treatment Services	Screening
	Home Care	Practice
	Dental	Nursing
	Involving Primarily	Dental
	the Computer	General

Section D: Management

Computers and Records

Hospital Business

Hospital Utilization
and Management

Hospital Information
Systems

Medical Information
Systems

Medical Records

Record Linkage and
Statistical Analysis

Automated laboratories

Ambulance Studies

Simulation-Education
Planning

Diagnostic Signal Analysis

Miscellaneous

Other Aspects

Nurses and Nursing Care

Health Personnel Generally
Pharmacy and Medical Equipment

Food, laundry, etc. Services

Laboratory

Miscellaneous

Section E:

Demand

Demand for Service

Related To

Population Generally

Mental Health

Dental Health

Special Populations

Hospitals

Emergency Services

Practices

Screening

Mental Health

Metabolics

Visual

Cardiovascular

Cancer

Hearing

Fetus, New Born, Infants

Genetic

General

Other

Section F: Prevention and
Promotion

General

Mental Health

Infectious Disease

Other

Accidents

Vehicle

Road and Accessories

Driver

General

Victim

Education

Standards

Genetics

Data Resources

Section G: Health Care
Research

Research Positions
Supported by Grants

In Epidemiology
In Biostatistics
In Dentistry
For Units
General

Methodology

Section H: Socioeconomic

Sociology of Health
Mental Health
Medical Students
Physicians
Family
Various Studies of large Groups
Interrelationships
Personnel
Family Planning
Emergency, Abortions
Other

Health Economics

Source: Science Council. Health Care in Canada - Dr. H. Locke
Robertson's progress report March 1972⁽²⁷⁾.

In a paper delivered to the Canadian Public Health Association in June 1972, Anderson(7) develops this theme about sponsorship and power to effect changes. He discusses the present processes of giving grant aid to researchers and evaluators who apply for National Health Grants in Canada. After reviewing the research methodology and the qualifications of the researchers, the granting committee consider whether each project is of sufficient relevance to be funded: "Here the reviewer finds himself asking a question such as 'if this well designed study were conducted as designed, and if the results were made known to the proper people, would some action be forthcoming or would a demonstration project be feasible?' It is this value assignment which is most difficult and which involves the greatest discussion at the peer review committee level." Anderson goes on to argue that health care research scientists are not the right people to make the decisions about relevance. "In fact the Lamontagne Committee recommends as essential a drastic change in Canada's priorities for funding curiosity-based research: thus in their bold look at our future, research in the social sciences and the humanities (are to) edge out life sciences' research for the highest priority. The decision on priorities then must be made by society." Later in the same paper Anderson suggests that a National Council of Health should set the priorities. Probably this Council would need to be advised by an Institute of Health Services Research and Development which would collect and sift data on general trends. "The Council should be free to 'view with concern' inappropriate or ill conceived changes in the system and identify the impact of changes upon the allocation of resources and the systematic development and distribution of medical care. Without such a Council we are at the mercy of unsolicited and therefore unplanned innovative proposals."

But will this National Council be sufficiently in touch with provincial and local levels? And can it hope to negotiate with the obstructive groups who do not want to know about change? Would this be the right body to authorize funding for evaluation?

It is important that evaluation should be independent but it could be argued that there are advantages in getting a sponsor nearer to the scene of action than a National Council of Health, particularly since many of the powers able to effect change in health services provision are at provincial and local levels. In fact 'evaluation' may have to be part of the package deal which is negotiated by regional authorities in planning

with the interested parties towards the development of a new system of care particularly if evaluation is seen to be part of a continuing process as Caro suggests.

EFFECTIVE EVALUATION

Suchman⁽²⁹⁾ distinguished between inside and outside evaluators and said that there were advantages and disadvantages in both positions. He thought that the inside evaluator was more likely to help with program development, or content, the outside evaluator is concerned with the development of standards. There may be a case for having inside and outside evaluators at a number of levels within the system of health care.

Even the most carefully designed and executed evaluative research does not automatically lead to meaningful action. Often it cannot produce results early enough to be a major factor in short-term policy decisions. "Rigor, timing and utility" seem to pull against one another. Results may be indefinite, show small changes and fail to discriminate between the relative effectiveness of alternative programs, says Caro. It is difficult to find out the impact in the short term, and on seemingly unrelated facts that do affect peoples' health, says New⁽³⁰⁾.

It is not going to be easy to develop evaluation activities. Evaluation creates great strain in the institutions being monitored. One problem is the amount of authority which the evaluator has. Others working in the organization may be geared to service rather than to research and may perceive research as limiting their service so they may not be very co-operative.

Another problem may be client activism which may develop a hostility to evaluative research through impatience to do new things before an evaluation has been completed and because some clients already feel that they have been surveyed too often.

"If one could influence the Hastings' study of community health centres...It would be to urge that they recommend a variety of well-defined models and that they establish a set of priority areas for innovation and demonstration drawn from their review of existing literature and experience. Only such a set of priority options will prevent an otherwise predictable

chaotic development of unco-ordinated and non-evaluated Health Maintenance Organizations; only this will enhance the likelihood of better peer review; and only this will reduce the inordinate duplication of the same unsuccessful innovation", says Anderson.

SUMMARY

There are four kinds of assessment: public opinion, consultant advice, managerial techniques and scientific evaluation. Usually these are used together. Interest in evaluative research is likely to be greatest where there is a predisposition towards gradual change. It is not of interest to conservatives or revolutionaries. It is most useful where it is to be expected that program effects will not be directly and immediately evident, where effects are subtle and diffuse and where there is greater distance between providers and consumers. It is most useful where a program is expensive, its impact is potentially great but uncertain and where the potential for diffusing programming conception is great.

Traditionally democratic governments have been kept informed through parliamentary mechanisms - letters, TV, parliamentary questions, pressure group activities. As the need for action becomes more obvious they may publish White Papers or set up Royal Commissions. Great Britain has departmental committees - the Hastings Committee is similar - which point to new administrative directions for government.

Consultancy is developing in Canada, particularly in the hospital service, but consultants have problems in working with independent agencies. The consultants' authority is ill-defined and the situation is confused because agency objectives are often not clear.

Consultants may make their most useful contribution at the design stage but they may also act as monitors. However, authority questions arise if they challenge existing powers.

The development of management techniques is advocated. Programs should be listed and examined and collapsed into a more rational scheme. There is need to move beyond ideological commitments (particularly in social services) to a properly costed and evaluated global program if general objectives are to be achieved.

Provincial governments need to begin with program review. This is difficult when provincial governments contract with voluntary agencies.

Other techniques are cost benefit, cost assessment, and operational research. They should lead to clarification of objectives, determination of priorities and balancing of organizational choices.

Beaudoin points to three steps in program development: initiation, contact, implementation: and five stages in program evaluation: systematic accumulation of facts; review of efforts, efficacy and productivity, differentiation of these three factors; use of technical methods; recognition of cultural context.

Caro describes scientific evaluation. He distinguishes studies based on (a) input (b) output data and says scientific evaluation is based on output data. Studies need to be made before, during and after (a) the planning (b) evaluation (c) to assess effects of implementation and may be repeated indefinitely. Evaluation may be formative or summative. It is a difficult process to carry out but worthwhile because health services expenditures are enormous. Though methodological problems are complex, social context problems are even more complex.

The basis for evaluation is recording. The principles of medical record-keeping are discussed. What data should be collected? recorded? what format? how filed? how retrieved? Much depends on perception of purposes. Physicians tend to see records as their personal property. Health centre physicians will have a natural reluctance to do more work for research purposes. Hospitals keep better records than offices because of audits and fear of loss of privileges. Can a similar system be introduced into community health centres?

But community health centres by definition depend on records as the centre of teamwork. Community health centre physicians should have a different attitude from their colleagues towards records as a basis for their work.

Computerization would lead to simpler and more effective recording and would be helpful for research purposes, because record standardization is an important question.

Problems relating to confidentiality will be numerous if records are computerized. Computerization may make it easier to keep family records together.

Capitation systems may mean loss of records now kept for billing.

Epidemiologists are not only concerned with the distinction between health and health care but also in relating the two by getting patients not only to comply with treatment but to seek it and attend for prevention and detection procedures of established worth. Should community health centres recruit patients, enrol them for care? Epidemiologists are concerned about the value of diagnostic screening. Pearson develops the concept of critical morbidity. Cost benefit analysis is urgently needed.

Donabedian suggests that there should be examination of outcomes, processes, settings i.e. structure and administrative processes. But the relationship between the three is not well established.

Buck says that whenever structure can be used as an indicator of quality it should be. Physical aspects can be judged much more soundly than administrative aspects.

As far as process is concerned, there are problems in relating it to outcomes particularly in relation to patient compliance, diagnostic techniques and some other aspect of processes.

Outcomes are not easily measurable but measurement might be improved. Training for evaluators is now available.

Sackett believes that a major question is which health professionals should develop which health services with which members of a community? He suggests that neither the public nor health professionals can estimate the value of health services without using evaluative techniques. Health care must be identified as a serious goal and be both relevant and feasible in its local setting.

Sociologists are less interested in outcomes than in processes and structures. Processes should be evaluated through

the eyes of consumers as well as those of professionals. An example of the sociological approach to evaluation is given by showing how the case study data was collected. The emphasis was on the dynamics of the change process. The importance of records, e.g. board minutes, personnel records, other than medical records was pointed out.

Research funding committees have been dominated by epidemiologists and grant applications may fail because they do not meet epidemiological or statistical criteria. The United States has been reviewing its approach to funding. Canadian health care research funding in 1970 is documented. Sociological research needs to be encouraged, particularly relating to emergent stages of clinic development.

The sponsorship of evaluation is such that the interests of the general public, practitioners and recipients of grants are not often fully served by evaluators. Studies are often made without effective political support and thus no action is taken on them. Anderson suggests that research should be funded only if it is sponsored by bodies which can implement change, or developed to answer questions posed originally by change agents, or if it reports back to change agents and includes specific recommendations relevant to appropriate and feasible change. He has suggested the need for the National Council of Health with an appropriate secretariat to determine research priorities.

Is such a council likely to be in touch with provincial and local levels? It is important for the sponsor to be near to the scene of change, though independent evaluation may have to be part of the package deal for community health centres.

There are inside and outside evaluators. Inside evaluators help in program development, outside evaluators with accountability for standards. Possibly both should be at a number of levels within the system.

Evaluation does not necessarily lead to results. Evaluation will not be easy to develop. It creates great strain in the institutions being monitored. The evaluators' authority needs to be determined and employees need to be convinced that they should co-operate. Research is also important as well as service.

Client activism may develop hostility to evaluative research for evaluation needs time. Anderson wants the Hastings' study to establish a set of priority areas for innovations and evaluations. Otherwise development may be chaotic and there will be duplication of the same unsuccessful innovations.

REFERENCES

1. Caro, Francis G.: Issues in the Evaluation of Social Programs. Paper prepared for Review of Educational Research, Institute of Behavioral Science, University of Colorado, March, 1970.
2. Maddox, George: Muddling Through: Planning for Health Care in England, Med. Care: Vol. IX, No.5, Sept.-Oct. 1971, pp.439-448
3. Klein, R.E.: Notes Towards a Theory of Patient Involvement.
4. Beaudoin, André: Indicateurs Sociaux, Congrès de la Fédération des Services Sociaux à la famille, mimeographed, Université de Sherbrooke, School of Social Work, 1971.
5. Klein, R.: Resources, Priorities and Planning in the NHS.
6. Observation by the Research Co-ordinator of a meeting of the Operational Research Group on Health Centres at the Scottish Home and Health Department, Edinburgh, Jan. 1972.
7. Anderson, D.O.: The Double Standard of Research and Development. Can. Jnl. of Public Health, July-Aug.1972 pp. 317-326.
8. Cherns, Albert: Social Research and Its Diffusion. Human Relations 22: 1969, p. 209-218.
9. Stake, Robert: The Countenance of Educational Evaluation. Teachers College Record, 68: pp. 523-540, 1967.
10. Mann, Floyd and Likert, Rensis: The Need for Research on the Communication of Research Results. Human Organization Research, II, No.4, Feb. 1969, p. 12-13.
11. Glass, Gene: The Growth of Evaluation Methodology, AERA Curriculum Evaluation Monograph Series, No.7, Rand McNally, Chicago, 1972.
12. Morgan, R.W.: Medical Records in Community Health Centres.
13. Murnaghan, J.: Johns Hopkins University, unpublished report of a conference on medical records, Chicago, March 1972.

14. Hewitt, D.: Personal communication.
15. Anderson, D.O. and Crichton, A.: Economies of Group Practice in Saskatchewan. Unpublished manuscript, University of B.C. 1972.
Anderson, D.O.: What Price Group Practice?
Crichton, A.: The Organization of Group Practice in Saskatchewan.
16. Wallace, B.B. and David, R.: A Record system for general practice. J. Roy Coll. Gen. Practit., 20, 1970, p.163.
17. Williams, J. Ivan: Privacy and Health Care. Can. J. Public Health, Vol. 62, Nov.-Dec. 1971, p.490-495.
18. Pearson, R.J.C.: The Cost of Screening: A Position Paper.
19. Buck, Carol: The Measurement and Improvement of Quality in Ambulatory Health Care.
- 20a. LeRiche, H.: Unmet Medical Needs.
- 20b. Sackett, D.: Evaluation of Innovative Community Ambulatory Care Programs during the periods of Social Change.
21. Donabedian, Avedis: Evaluating the Quality of Medical Care. Milbank Memorial Fund Quarterly, Vol. 34, 3, part 2, July, 1966. p. 166-206.
22. Logan, R.F.E.: Personal communication.
23. Draper, Michael: How can the Quality of Ambulatory Care be Improved?
24. New, P.K., Belanger, P., Fish, D.G., and Crichton, A.: Guideline for Collection of Data on Community Health Centres.
25. Ruderman, Peter: Economic Characteristics of Community Health Centres - Summary and Conclusions.
26. U.S.A.: Review of the Work of the National Centre for Health Services Research and Development, mimeographed, Sept. 1971.

27. Robertson, H. Locke: Health Care in Canada - Progress Report And Commentary. Background Papers for Health Sciences Committee of Science Council of Canada, March 1972.
28. Anderson, D.O.: Personal communication.
- 29a. Suchman, Edward: Evaluative Research. Russell Sage Foundation, New York, 1967.
- 29b. Suchman, Edward: Evaluating Educational Programs: A Symposium. The Urban Review, 3, No.4: Feb. 1969, p.15-17.
30. New, P.K.: Personal communication.

CONCLUSIONS

THE QUESTIONS

The community health centre committee was asked to direct its attention to the following questions:

- (a) would community health centres increase accessibility to health care services in Canada?
- (b) would they improve acceptability?
- (c) would they reduce cost escalation? or at least reduce the cost of the medical care component of health services?
- (d) would they provide greater opportunities for skilled health manpower to be used more effectively?
- (e) ought they to offer consumers more chances to become involved in the planning, management and operation of health service institutions?

The questions are political. The answers will be political.

DATA COLLECTION

This report is based upon expert opinion. Whilst searching for evidence, attempts were made to find "hard" data to put against normative data. These attempts were not very successful. Where community health centres exist they are "demonstration" models and have many problems in operating because they are not part of an organized system of health centres. Measurements of their work have seldom been carried out and, where they have, researchers have been left with many questions which cannot be answered properly because of the effects of the surrounding system upon the variables considered. As well, it is not known whether the personalities and missionary zeal of many of the innovators have been a factor in the success or failure of the demonstrations.

WHAT ARE COMMUNITY HEALTH CENTRES?

COMMUNITY HEALTH

The concept of community health is the concept of healthy individuals in interaction with a healthy physical and social environment. Unfortunately, today, in urban societies, both individuals and communities find it difficult to achieve the state of being in optimal health. Individuals do not obey health rules, urban communities are not easily identifiable because their members do not have a clear sense of identification with them, some become alienated, most find life stressful at least for part of the time. Rural communities feel cut off and neglected. Medical care can deal with some health problems but not all. Whilst biomedical technology has been advancing very rapidly in the last 30 years, it has not done as much to improve health as economic advance which has led to a better standard of living. However, biomedical technology promises better health or at least longer life, which has been a predominant value in Western society, a value now beginning to be questioned by social policy makers but still accepted at the personal level.

COMMUNITY HEALTH CENTRES

The development of community health centres would be an attempt to find a different balance in health care away from the excesses of biomedical technology. Community health centres would emphasize the continuing assessment of health care needs for the "worried well" and continuing care for those with illnesses or disabilities - surveillance (but not screening except where the course of the disease can be altered), maintenance and restoration. The community health centre concept of health is more than a matter of physician checkups and professional interventions, it is, as well, a concept of assisting individuals to make psychosocial adjustment to their environment. It is also concerned with keeping people out of institutions as far as this is possible.

A successful community health centre has to be part of a general system of care which links primary, secondary and tertiary medical care so that returns and recalls may be made when necessary and consultancy is constantly available.

It is suggested that community health centres might be made up of modules - small teams which could give full-time or

part-time services within a regional district. This should enable the centres to provide general care and specialist services, such as youth advisory sessions, family planning clinics or mental health clinics which do not need to be open every day but should function at intervals. Being part of a regional system, the community health centres should also be able to reach agreement about the provision of services at hours suitable to the local population and to the community health centre staff. Thus the responsibility for urgent care could, if necessary, be shared with other clinics or the local hospital, and gradually patients might be trained to make better use of continuing care services. It is envisaged that the community health centre would need to have an enrolled population for the purpose of giving continuity of care to individuals and building up information about its clientele.

The community health centre might become much more than a medical centre waiting for patients to come to ask for technical medical care services. It might first develop a receiving or problem sorting function to individuals within its walls and later extend this out into the community. Many people do not now know where to seek help and may reach one professional rather than another by chance, or they may never be able to get the professional help they need because they cannot find their way into the health or social services systems.

In order to provide outreach problem sorting services, the community health centre needs to develop teams of indigenous workers paid or unpaid, who can tell friends and neighbours about available helpers. Freidson demonstrated a number of years ago that before people seek the service of professionals they will use a 'lay' referral system.

As well, professionals may be located at strategic points in the community for the purposes of case-finding or information-giving-pharmacists in retail stores, visiting public health nurses, and non-health professionals, such as ministers or policemen, might be linked to the community health centre for this purpose. Again, a record system is of vital importance if community needs are to be explored and action taken.

The CELDIC Committee thought that 25% of children had problems but only 3% needed intensive professional help. Professionals have not been very good at sorting out the problems

which do reach them. Physicians will not usually turn away those who come to them for help with psycho-social problems, except for 'nuisance' cases - the mentally retarded, alcoholics or drug addicted, the depressed, difficult youngsters, the elderly, and those with emotional problems whom they will be glad to refer. They will keep other problems which interest them. They need to learn how to delegate.

Some people also believe that a community health centre should be the nucleus of community development. The professionals in the centre, working together with the local people, should be able to stimulate a new level of community consciousness and community involvement for the purposes of improving the quality of life in the locality. Others are not certain whether this should be the function of a health centre where physicians may dominate and medical treatment theories prevail. Social workers and community developers may prefer to work from other bases. Much depends upon the administrative structures which have developed in different provinces and the experience of different professionals in working together.

THE EXISTING SYSTEM

COST-SHARING

Presently, the administrative divisions between the federal shared-cost programs have created a whole series of medical care systems which are not efficiently interlocked. The new federal cost-sharing proposals might remove the administrative barriers between hospitals, personal practitioner services and public health and mental health services if the provinces decide to take action to set up new co-ordinating machinery, but the recent federal proposals do not link health and welfare grants any more closely than now.

Consequently, any new system which might be developed would be a medical care system unless (as in Quebec) the provincial governments bargain to opt out to get an 'untied' grant to be used for any desired provincial purpose.

The evidence which is now available indicates that more money put into medical care may not result in better health outcomes. Money may be better spent on nutrition, or the

support of neighbourly helpers or the development of recreational facilities rather than health professionals' services or drugs.

However, it seems unlikely that, at this point in time, health and welfare grants from federal to provincial governments will be merged, and provincial governments other than Quebec have not yet strongly indicated a desire to opt out and take one block grant from the federal treasury instead of the tied grants. Consequently, any immediate reorganization of the system in provinces other than Quebec is likely to be more re-organization of the medical care component than of health services as a whole though this reorganization does not preclude the development of supportive social work services and community involvement in the planning and management of community health centres.

The present federal-provincial cost-sharing formulae will inhibit the development of community health centres. Innovative services may qualify for help from Health Resources Funds if they have a teaching component, or for demonstration grants. But as has been pointed out, demonstration grants are sponsored by those who have no power to ensure that findings are put to good use.

Case studies showed that all types of innovative health centres had great difficulties in obtaining funds to try out their ideas.

CHANGING THE SYSTEM

Community health centres by themselves could not deal with all the deficiencies of the medical care system but the introduction of viable community health centres might begin to make a difference. To fund more innovative demonstration units would not really be very useful without also bringing in some systems change, for new demonstrations would be unlikely to confirm or deny what is already known, and that is very little, though it points in the direction of developing community health centres.

LINKING THE SEPARATE SERVICES INTO A PLANNED WHOLE

Unless a program for community health centres is introduced together with some program for co-ordination, for rationalization of the present system, this will result in a greater proliferation of competing services and more cost to governments.

The pluralistic system at local levels will need to be brought into one linked system at least at provincial level and possibly lower down within a regional district organization.

The federal Minister of Health has said that he proposes to set up a Health Council and the Second Manpower Conference wanted to see provincial Health Councils developed too so that general policies for health care might be worked out. Many reports have suggested that regional authorities should also be developed for (a) planning (b) operational control of health services. The concept of 'region' is ill-defined, however.

The system of providing health care may be reorganized on two levels (a) coordination of services or (b) integration of services.

Integration presumes that there is a "parallel movement of unifying goals and professional techniques"; coordination, that there is some streamlining of the present wasteful system.

The prospect of attaining unified goals and unified professional techniques in Canada is not great, because it is a society which values pluralistic solutions. Thus it seems likely that where community health centres are introduced they will form only part of the primary care system, and that other forms of medical care delivery will co-exist.

However, Quebec is aiming at an integrated service to be developed in time. In the long term, 3% of physicians only are to be allowed to contract out of the medical care system although in the short term the government has had to agree to the existence of (a) the private sector, (b) the privately sponsored clinics giving publicly financed medical services and (c) the evolving community health centres. As well, community health centres are being linked in to the social service system which is also trying to rationalize its agencies into providing a less complex series of programs.

There is a spectrum of provincial social policies in Canada which at the one end is entrepreneurial and, at the other, is socialistic, both being far from the extremes of either viewpoint. Overall, the federal government, a Liberal government (whatever that label may mean in 1972) appears to lean to the entrepreneurial view, so that economic development and national strength through

economic growth seem to be put before social development. The ambiguity lies, of course, in the difficulty of separating out political objectives because a minimum level of social development is necessary for economic strength, and in fact this may not be a political philosophical position but a necessary federal government position.

Quebec, Manitoba and Saskatchewan have developed more of a 'welfare state' ideology than the other provinces and Quebec has even gone so far as to legislate for community health centres to be set up, but in all provinces changes will have to be made slowly, or the medical practitioners will "strike, stint or flee".

Since integration seems to be impossible, how then can co-ordination best be brought about? Co-ordination is necessary both horizontally between public and private sectors and vertically for improved technological standards of service.

REGIONAL AUTHORITIES

Quebec proposes to establish regions based on a concept of primary, secondary and tertiary referral centres. Since tertiary referral centres are centred on university medical school research/service hospitals, it is only in provinces with more than one medical school that such a concept of regionalization can be applied.

It has also been argued that there are advantages in establishing regional authorities to link up with metropolitan planning authorities, and to ensure that scattered rural populations receive health services. These regional authorities would not necessarily have tertiary care centres in them but only primary and secondary referral centres. To some extent, it may be advantageous to community health centres not to be in regions dominated by tradition bound medical school specialists for community health care has, perhaps for too long, been regarded as low status by those who are hospital-centred.

The extent of decentralization of power by provinces to regional districts and from regional districts to local communities needs clarification. The extent of decentralization will depend upon the weight given to planning and rationalization and consumer involvement. The greater the decentralization,

the more the consumers will become involved but the less chances there will be of streamlining the provision of services. At present, the indications are that the provinces are not very willing to let go of the purse strings to such regional authorities as now exist. Nor are unionized or other highly organized professional groups likely to be willing to negotiate pay rates at a lower level than that of provincial negotiating boards.

OBJECTIVES OF REGIONAL AUTHORITIES

It seems to be clear from the evidence collected, that to establish new regional authorities without carefully thinking through their purposes would not be helpful.

The main function of authorities (whether provincial or regional bodies) would be to plan and budget for essential services and to develop incentives towards gradual change. The necessary beginning would be to make inventories of services, to discover gaps and overlaps and to consider how best to deal with these.

Two purposes of regional authorities have already been mentioned (a) planning, (b) operational control. Yet another purpose of regional authorities can be (c) education about the functions of health care organizations. Both consumers and health professions would have to work to develop an awareness of the others' points of view and to be open-minded enough to learn from each other.

Clearly the composition of these regional authorities would be dependent upon their objectives. These might have to be a series of separate committees to work towards the three objectives outlined above and towards other purposes viz: (d) dealing with complaints and (e) providing consultant and evaluative services.

This breakdown of objectives suggests that there are some regional committees which ought to have more consumer representatives and some which ought to have more technical professionals as members. The consumers might have a greater contribution to make to the educational and advisory policy making committees. So it might be important to try to develop a hierarchy of advisory committees or complaints-investigating committees in order to ensure that consumer education was begun. Later these committees might be given more authority after they have developed expert knowledge of the workings of the system. The importance

of defining the roles of committee members and educating them about their roles has also been stressed.

THE NEGOTIATION OF CHANGE

There are beginnings of new structures emerging, dealing with planning and control of capital investment in the health service and, to a more limited extent, operational activities.

Whether direct financing is used, or "contracting" continued, the provincial governments of the regions or community health centres acting on their behalf, if it is decided to delegate real power downwards, will have to negotiate with the others who hold power--the physicians and the hospitals being the two main power groups at present.

The business managers of group practices made a strong case for having a change in the principals who should be recognized in negotiation. They wanted to see negotiations occur between provincial governments and group practice representatives. If community health centres are to be developed, it would seem to be very important to consider this point, for a change in negotiation structures is the only means by which it will be possible to get away from the present power groupings which put only the medical associations and the hospital associations across the table from the provincial authorities. Whether it should be group practices with whom negotiation takes place or community health centres or both is another question, but it does seem to be vital to shift away from identifying the medical associations and hospital associations as the only bargaining agents if new forms of "anti-hospital" teamwork are to become the key to community health centre developments. Professional colleges will, of course, always remain important licensing bodies responsible for professional standards, but this is not the same as being bargaining agents for terms and conditions of service as was clearly recognized in Saskatchewan in 1962.

WHERE THE SAVINGS LIE

The regional authority (be it a province or some smaller area) would need to develop financial mechanisms to change the present incentive systems in health care. Presently, it pays consumers of health care to go into hospital and physicians to put their patients into hospital.

Hospitals are the status high centres of medical care and the centres of medical education and communication.

There is need to link hospitals to clinics more closely and to change the incentive systems so that, when possible, patients are not treated as in-patients when out-patient care would be satisfactory. The problem is that there are no clear standards. The British decision to keep acute beds to 2 per 1000 may be relevant to the United Kingdom but not necessarily to Canada. It is clear, however, that beds must be reduced in order to protect doctors from patients clamouring for admission to hospital.

There may be dangers in giving direct incentives to physicians or clinics to keep patients out of hospital when they need to go in for treatment at an early stage of illness. As well, patients in lower socioeconomic groups or others without extended family supports may need more access to hospitals or more money to pay for extra services when being treated at home. For change to be brought about new payment procedures will have to be negotiated. A beginning has been made in some provinces where community clinics have been recognized as hospitals for the purposes of global budgeting, but the present federal legislation regarding cost-sharing prevents linkage between hospitals, medical care, public and mental health service funding and research/evaluation. However, hospital-type structures are not necessarily the most effective structures for community health centres.

THE DEVELOPMENT OF GROUP PRACTICES AS A PARALLEL OR INTERIM STEP?

Despite Ruderman's findings that group practices as presently constituted are not economic, it would appear that getting professionals into group practices does seem to offer a better prospect for movement toward community health centres than building on to hospital organizations. However, this does not mean that hospital physical structures cannot be used.

At the present time, group practices are very unstable organizations. Their formation depends upon doctors' willingness and ability to form partnerships with or without involvement in ownership of premises. They have no legal entity as corporate bodies.

Several partners in group practices explained that it was more by luck than by judgment that they were grouped. Some lucky financial break had come along or a particular set of circumstances had made it favourable for their group to be formed. A study of 17 groups in Saskatchewan showed that there was an extensive and rapid physician-turnover. It was clear that either their colleagues or the patients or both were having to pay for this mobility by having less satisfactory input from new members of the groups.

The theme of the business managers was the uncertainty of their groups' position. They would have liked to have had more control over the group practice businesses, and they blamed their provincial governments and the universities for changing the rules or the referral patterns, so that they could not plan ahead properly. Blaming these others seems somewhat unjustified, but the reasons for it are obvious, for the present system of financing groups is unsatisfactory.

THE FINANCING OF GROUPS

A distinction can be made between capital costs (buildings and equipment), start-up costs, working capital (is working capital now necessary at this stage of medicare development or only petty cash?) and operating costs. Much of the uncertainty of the groups seems to have been associated with the lack of capital to get started properly, resulting in long-term debts and the continuing high interest charges which have to be paid on them. Once these are dealt with, operating costs are much easier to control. These are strong arguments for a low interest loan fund to meet these starting costs or reconstruction costs.

As far as operating costs are concerned the evidence about the best methods of financing group practices is not clear. There seems to be no good reason why the groups themselves cannot be allowed to work out their own payment systems within a global budgeting arrangement whether they choose time-rate salaries or piece-rate payments by case or by session (they are doing this already). It would appear to be unlikely that community health centres could succeed within the present fee-for-service system because one of the basic criteria for the success of a centre is teamwork and teamwork implies an equality in methods of remuneration if not in levels of remuneration. Fee-for-service

paid only to physicians as at present would put them in a position of authority inconsistent with problem-centred teamwork in which each team member contributes according to his special skills.

Consequently, global budgeting seems to be a sine qua non of community health centres. Presumably the centre could then decide how to remunerate its teams, and might decide on fee-for-service payments. If, however, other staff were given an equal say with physicians in the mechanics of remuneration this seems unlikely to be the outcome. New groups will need help, and community health centres even more help if they are to develop a teamwork remuneration system. A consultancy service of accountants, work study experts, health professionals and social scientists should be able to develop criteria for and with them.

THE REFERRAL SYSTEM AND COMMUNICATION CENTRES

It is important for the future of ambulatory care in Canada that community health centres are not developed as second-rate centres, so they will have to be in at the heart of the medical profession's informal communication system. Despite the obvious dangers of building on to any existing parts of the present system, it would appear that the struggling new system of group practices is most likely to offer a sound foundation for future developments, for system reorganization.

But if group practices are to be the basic units of ambulatory care, then group practices themselves must begin to provide the communication network and educational facilities for ambulatory care, or special regional centres for this purpose must be built. Physicians must be weaned away from the hospitals which are not a proper centre for their interests if they are to be mainly concerned with keeping people out of hospital, with teamwork and with problem-centred care.

The health sciences centre concept is still mainly associated with in-patient tertiary care, though it is an important concept for community care.

The Mustard Report suggests a system of satellite educational centres for physicians sponsored by universities and this kind of backing may help not only to support the group practices but also to bring the universities more out into the community care system. But the centres need to provide services to other professional groups too.

The role of universities in community care is not clear, and needs to be clarified. Obviously students should be trained in community health centres, but whether universities or community colleges should give continuing education courses is more doubtful. The funding of courses needs proper consideration, as do teaching methods and curricula.

RELATIONSHIP OF SPECIALISTS

A regionally planned service should ensure that primary care patients who need help are sent on to secondary and, if necessary, tertiary care. Consultants from tertiary and secondary levels should be readily available to help primary care teams.

The location and use of specialists will be very important. It would seem to be vital to ensure that they too spend much of their time outside hospitals working with colleagues in community health centres, being available to them for informal as well as formal consultations. A travelling consultancy service might be developed on a sessional basis. Specialists would have to conduct more out-patient clinics. This change in orientation will not be easy to achieve. Probably most continuing education should be given by this means.

Although this has been a study of community health centres (and because of that mainly of family physicians), it has become clear that there is immediate need for another separate study of the specialists in Canada and what is to become of them. Until their problems of making a living are studied, they are likely to work against the community health centre concept because they will put pressure on the non-specialist for referrals and will continue to use hospital beds and hospital moneys.

The community health centre concept cannot properly be worked out unless it is backed up with well-organized secondary and tertiary referral centres. The specialists are quite unorganized and the university link-in to the system is even more disorganized. The need for the development of a teaching and consultancy service is urgent.

The importance of the present medical referral system must not be minimized, for unless it is changed, unless general practitioners begin to refer to their allied health professional and possibly even lay colleagues, the new concept of teamwork will not get off the ground. But the medical referral system is

at the core of the medical profession and there will be great resistance to change on several counts. Primarily, general physicians have got used to referring technical problems upwards to specialists, (as Rein says, it is a matter of accountability, it is safer to refer upwards); next, they do not know how to refer as easily to other professionals whose training is different; and, of course, the specialists are part of the medical professional network which bind physicians together, and the referral system is their real power centre which they will defend from outsiders' intervention.

FREE CHOICE OF PHYSICIANS

The principle of free choice of physician is a principle which is highly regarded in Canada, but this principle conflicts with the concept of continuing care -- surveillance, maintenance, and restoration of the sick. A systems concept would require linkage of patients' records, at least, so that some continuity can be achieved.

There are strong arguments in favour of enrolment of patients with clinic groups in order that the inertia principle should begin to operate and patients be discouraged from 'shopping around'. Other advantages in enrolment are related to the making of regional epidemiological surveys, identification of communities' special needs and information feedback to local health care teams.

It seems unlikely that it would be politically and administratively possible to alter to a major extent the concept of free choice of physician. However, it does seem to be necessary to set some limits upon this in a planned system. There are several possibilities:

- (a) set geographical limits within a health centre district or region,
- (b) have a short period of lock-in (2 weeks to 3 months) to develop the inertia principle,
- (c) develop incentives for enrolled patients,
- (d) separate continuing care from 'urgency' centres (e.g. youth clinics, hospital emergency departments) and charge deterrent fees for use of more than one service unless linked.

One or all of these might be used to control the present mobility of patients and bring it down to a lesser level.

However, patients cannot be expected to enrol for any one clinic's services unless these services are given at times appropriate to the patients' needs or unless there is a recognized link between clinic and emergency department services. Regional planning should ensure that a primary care service of minimum standard is accessible to all who wish to use it, and possibly those who do not at present. It was suggested that a good service might have to try to "recruit" the non-users.

LEGITIMATION OF CHANGE

The evidence about health care processes indicates that these were regarded as coming solely within the jurisdiction of the medical profession in the past, after a decision had been made to seek for professional medical care - to become a patient. But now that the taxpayer pays, and all are entitled to health care, the dominance of the medical profession is being challenged. Politicians who are channelling the tax moneys from the public to the profession are asking questions about efficient organization. Patients are asking questions about the physicians' mandate. They are beginning to perceive a distinction between clinical decisions and organizational decisions and between medical care and health care. As well, epidemiologists are challenging the reliability and validity of medical clinical decision-making. Whilst therapies are quite well organized, diagnostic processes are not altogether satisfactory.

Politicians have started to get public support for changes by continually raising what they consider to be the relevant questions. As yet they do not always present relevant answers, because there are not comprehended, except in part. But politicians are engaged in a process of legitimizing political and administrative efforts to make changes. There are likely to be resistances by the public to drastic changes and particularly by interest group leaders such as local businessmen, hospital administrators, and medical staff chairmen to hospital cut backs, and by physicians to loss of income or autonomy.

INTERNAL ORGANIZATION OF COMMUNITY HEALTH CENTRES: SOME PROBLEMS IDENTIFIED

CONSUMER INVOLVEMENT

How much community participation should be encouraged? Apart from questions about government sanction and government funding of regional and provincial consumer participation, decisions will have to be made at the level of the centres themselves about consumer involvement. Deprived groups have more to gain by becoming involved, but they will be less able to cope with the relationships which they will have to learn how to make with professionals and among themselves.

Since 'consumer involvement' threatens the self-concepts of professionals they are greatly concerned about its implications for their autonomy.

Much of the uneasiness about the present system of health care delivery is related to the feeling that Canadians are not getting value for money. The measures of health outcomes have not shown any great improvement in mortality and morbidity to offset the steadily rising cost of health services. Patients are not satisfied with the processes of diagnosis and treatment to which they are being subjected. They resent what they perceive to be bureaucratic, technological, impersonal care at times when their needs for social support are great. Physicians, desirous of preserving their autonomy have been anxious to maintain control over the doctor-patient relationship not only in terms of clinical processes but also in the administrative processes surrounding their clinical work. They have not been very willing to admit that there is a distinction between discretionary decisions and the 'the qualities of procedures attending a decision'. The structures of health care institutions have only just begun to be questioned as medical dominance and medical omniscience have been challenged, but new structures are not yet clearly visualized by many people.

Because of the O.E.O. philosophy and concept of community development through management of U.S. neighbourhood health centres, community participation or involvement has come to have a restricted meaning for many people. But participation in community health affairs does not necessarily have to mean

involvement as manager, adviser or a member of the board of a community health centre. Many other methods of community involvement are possible. There is the Fish scheme whereby neighbours keep an eye on elderly people living alone; the Americans have 'block parents' who supervise and aid school children on their block. There are co-op day care schemes, day hospitals for geriatrics and volunteer escort schemes. But participation which is to be effective does need to be organized, at least to some degree, and it needs to be recognized as an important contribution from the community.

Because deprived communities have more resentments it may be more difficult to develop new forms of involvement there, but, on the other hand, they have much more to gain through becoming involved, so that it may be important at least for some community health centres to be started in deprived communities.

Consumer involvement may mean involvement in paid work as well as in volunteer work, particularly in poorer districts. The transition from consumer to provider of services may mean that the worker has considerable difficulties in knowing how to identify himself and his loyalties. This creates considerable stress and the "interstitial" positions with their ambiguities have long been a subject of study for sociologists. There are likely to be many role confusions and much learning to be done.

TEAMWORK

Another aspect of learning will centre round teamwork and its implications.

The central concept of the community health centre is teamwork. The kind of teamwork which is meant is not the kind of teamwork which has been developed in hospital operating theatres, a paramilitary system to deal with inert patients, but the milieu therapy approach, developed first in mental hospitals and later in community psychiatry. This approach recognizes that all those who have contact with the client may influence his behaviour and his self-concepts, but that professionals have a special responsibility in making their interventions not only to help the patient but to help others to help him, and to help him to help himself.

The focus is not upon the physician as team leader but upon problem-solving processes for the client/patient. Naturally, the physician is better equipped to diagnose organic problems, but other members of the team may have more useful contributions to make to psycho-social or social difficulties, and this approach focuses upon helping the patient to take greater responsibility for his own health (as expressed in the Health Charter of the Hall Commission) and the community to take greater responsibility for its members.

It has been suggested that community health centres could best meet the needs of local people by developing a core of family physicians or physicians' assistants services including all the important support services together with additional services provided by specialist teams. This modular development of small teams is unlikely to move towards the economies of scale which were considered by the economists in their study if groups or community health centres are considered as single units. But if community health centres became part of a system, then specialist teams could be established working out from the regional headquarters whether on a full-time basis for a period of some years, or on a weekly or monthly part-time sessional basis. Youth clinics, family planning assistance, community mental health services, dietary advice are seldom needed full time but are important extras for a community.

As well, specialists in other community care services could make sessional visits whether as clinicians or consultants as necessary. Global budgeting would allow the community health centre to decide how best to use their services since they would have to fit in with the fee-for-service schedules.

The crisis centre telephone answering service for the city and the retail pharmacy store could both be linked to one or more community health centres. The concept of satellite services is key, if available manpower is to be properly used.

One of the problems at the present time is that many people are not getting to doctors' offices (even where services are available) and when they get there they may have presented themselves to a service less appropriate to deal with their problems than other agencies which would help them or could be developed to help them. Many people are concerned about the sorting process which goes on before people get to health and social service agencies and after they arrive. The improvement of communication about services within the community and communication back from

the people is thought to be one of the principal functions to be developed by a community health centre. In the U.S. much attention has been given to this communication development role of intermediaries or indigenous workers or volunteers in middle-class areas for it is thought that professionals have failed in communicating with many groups of people, not only through language but also through symbols.

PHYSICAL PLANS

As well, the physical plans for community health centres can indicate attitudes of welcome or rejection and design of offices may promote or deter teamwork. Since the attitudes of professionals are likely to be slow to change, the importance of well-designed premises may be great, for this may force new patterns of work to emerge.

If the community health centre is to provide more acceptable services, to provide more openings for skilled health professionals and to offer more opportunities to consumers to become involved in the running of centres, then people other than physicians must be allowed to get involved in reviewing delivery processes, and organization structures require to be changed.

The sociological description of an organization structure which would permit this change is "participant bureaucracy". This term implies a well-organized but flexible method of linking together the elements making up a centre and the system as a whole. Although lines of authority and responsibility would be clear, these would differ from those presently existing in medical practices. Because income is collected mainly from the individual doctor's fee-for-service earnings, confusion tends to arise within group practice organizations. Workers have a complexity of loyalties--to the individual physicians by whom they are paid and for whom they seem to be working, to their profession, to the practice group - and these may conflict at times. As well, some would like to develop more community involvement and have more responsibility to the local people.

Conflict of loyalties can be diminished if the community health centre can be organized to meet the problems which have to be solved for and by the local community, and if payment systems are changed so that it is the centre which is paid for

services, not the individuals within it. This change in orientation will not mean that physicians will lose their authority, for their expertise will still be recognized. But it will mean that the staff can spend more time thinking about the problems of the patients than their own problems of security of tenure or about how to satisfy the doctors' demands and the administrator's rules at the same time.

DEVELOPING A COMMUNITY HEALTH CENTRE

The range of services to be provided in a community health centre will be decided by the sponsors of the centre according to their ability to bring in and redistribute resources -- financial resources, manpower, equipment, personal attention, etc. This range of services will probably be determined quite early on in the development of a centre and may not be easy to change much thereafter. So it is important to get technical help early whether from their own business managers on financing and staffing, or from consultants on structures and methods of working. Their ability to tap funding mechanisms and draw in skilled manpower is likely to depend upon their willingness to negotiate satisfactory terms and conditions with the purse holders and the professionals.

The key to satisfactory negotiation is the clarification of objectives, coupled with an attitude of willingness to be flexible, to make compromises on the part of all the negotiators.

It is important to recognize that those involved in negotiating the development of a community health centre will have different priorities. New has said, "Usually health professionals are not adequately trained to understand what the community, external to health services delivered, has to do with the good or bad care that is given."

There will be power struggles. These should be anticipated and thus, to some extent, defused.

Personnel management will be very important. Good terms and conditions of service, attention to matters of recruitment, contracts, deployment, training, negotiation and consultation will be very necessary. It may be essential for community health centres all together to work out some generally applied scales

of pay, retirement programs, etc. in order that their staffs can begin to get the benefits of attachment to large organizations such as hospital employees or university staff now have. This would appear to be one of the most important incentives to get skilled workers to consider going to community health centres, as an alternative to entrepreneurial forms of practice. Incentive schemes could be developed for extra special services -- long hours, weekend work, outpost service.

EVALUATION

Four types of assessment were identified: public opinion, professional expert opinion, management techniques and scientific evaluation. Most countries use a mixture of these four to evaluate their health services. None is well developed enough to provide a sufficient assessment without the others.

It has been argued that the most important in a stable society are the first two, for rational assessment by itself is inadequate. However, there is no doubt that rational assessments may assist in developing more efficient and effective policies and programs.

It is easier to evaluate specific programs than general policies. Yet evaluation is likely to be most useful for getting to grips with assessment of programs such as those in health care or education which are imprecise, diffuse and broad in impact.

The funding of evaluation is presently inadequate. National Health Grants are now awarded on the advice of independent committees of professional researchers in health care. But the difference between the approaches of the different disciplines which are involved in health care research have been minimized and the advice of epidemiologists predominates. They do not understand well the sociologists' approach, and their techniques of research and their values are not the same.

Some concern has been expressed about the isolation of federal research advisory committees from the sources of power which could promote change in medical care. This separation results in the funding of repetitive demonstration studies or research projects which may be remote from the real issues of the day. Should research continue to be sponsored by National

Health Grant committees advised by the proposed national Health Council about research priorities as has been suggested? Should responsibility for evaluation of specific programs be decentralized to provincial (or regional) authorities where the power lies? Should provincial health councils be established to take responsibility for funding evaluation of community health centres? These questions need to be considered immediately because community health centres should not be introduced without 'before and after' studies in order to learn more about the criteria for their success.

STRATEGIES OF CHANGE

To sum up: there are many difficulties to resolve, but it would appear that the development of community health centres would be a useful next step in improving Canadian health care delivery.

It is clear that community health centres will not be successful unless they become part of a total system of care, and that at the same time the present system will have to be changed gradually.

"The strategy of the change is as important as the change itself" and each provincial government would have to feel its way towards solutions.

Alix takes the view that although some people may wish to rush into developing community health centres, this would be unwise. The essence of his concept is intensive interaction between the local people and their developing community centres. The centres should not be started unless the population is ready for them and unless the professionals are ready to work in a new way with the population. Most populations are ready, he says, where needs are great and traditional forms of delivery are inadequate, whether geographically, economically, psychologically or culturally.

So where is it best to begin to introduce community health centres? Some think that it is not only services to the poor which need to be improved, but services to all classes of society. Beginning to develop community health centres only for the poor is not likely to be the best move because

they may fail to attract good staff. As well the poor may have more resentments and so make very great demands on the staff who could find it difficult to respond in an acceptable manner.

Demonstration projects appear to have been of several kinds: (a) group health centre or community clinic models (b) hospital outreach models (c) expanded nursing role models (d) experimental clinics developed by universities for teaching or by medical students (e) experimental clinics developed to meet the needs of youth or minority groups (f) expansion of existing services such as occupational medical services to local communities.

Of these, the group health centres have been particularly concerned about medical care standards, the nurses have been anxious to demonstrate new uses of skilled manpower and the others have been anxious to improve accessibility to, or acceptability of, service to deprived groups. It would appear that encouragement should be given to sponsors to develop all kinds of models provided that they meet certain basic criteria of health centres and community involvement. What is important is that the centres should move beyond the 'missionary' stage into an ordinary alternative model stage, and that there should be enough of them to form "a critical mass".

By undertaking "before and after" studies, evaluators should be able to assess the criteria for further successful development of community health centres.

The speed at which change can be carried out is very important. Armstrong has drawn attention to the possibility of physician emigration if rapid changes are forced, but he may be overly pessimistic. Quebec and British Columbia are making quite rapid changes. But fiat does not seem to be the best method of making change. There must be incremental change by negotiation. Much of this must go on behind the scenes.

Many have warned that it will be another generation before the present group of physicians cease to obstruct change and, until they do, teamwork as described above is unlikely, for change is not going to come after the end of professional training. At that time behaviour is learnt and deeply internalized. But again this is to be pessimistic. There may be other mechanisms which can be used.

It would seem that well-designed centres together with good evaluation procedures might bring about more rapid adaptation than waiting for the educational system to work, particularly when the education system itself is caught up in the same problems of being unable to bring in changes.

A health care system is dependent upon its health professionals and a tension exists between professionals and society about the extent of the mandate which they can expect to be given in return for their expert services. In the past, professionals were given a very broad mandate -- the minister, the doctor and the schoolmaster were not only technical experts but social leaders of a rural society. Physicians are not noticeably wiser about the problems of the world today than other members of society. Now, particularly in the U.S., there is considerable disillusionment with the way in which professionals and semi-professionals have used their power. Rieff says: "The professions cannot be entrusted with the social responsibility of being the 'guardians' of knowledge...The bitter experiences of the poor have taught them that the professions have identified the promotion of human welfare with the interests of the dominant class. Finally, they are demanding greater accountability to themselves -- in the form of community control, for example -- not to those who have traditionally oppressed them. The meaning of accountability of the professions to the community must not be limited to management and control, but must be extended to include accountability in terms of knowledge. Community control too often is only concerned with matters of management and administration of the professions... (It) must concern itself with making the professions accountable for the way in which they use their knowledge. Every professional must be required to educate his clients and the public about what he is doing and why...(For professionals) tend to organize their use of non-professional knowledge and skill for their own purposes rather than the client's".

"The revolt of the consumer is not only against the medical profession attempting to assert its autonomy, but also against the 'technologization' of medicine," says Klein.

